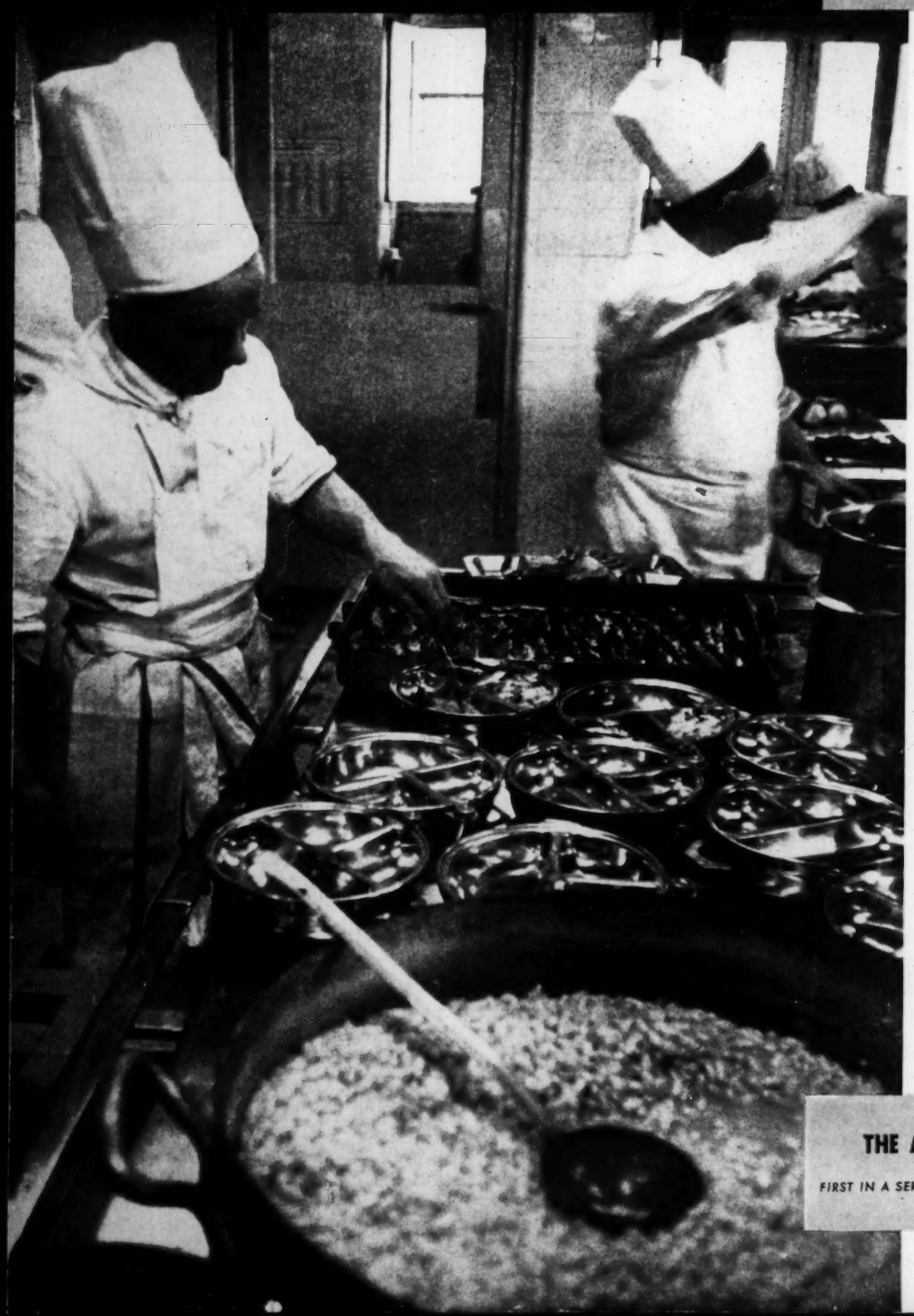
HOSPITALS

JOURNAL OF THE
AMERICAN
HOSPITAL
ASSOCIATION

NOVEMBER 16, 1957



Bedrails:
Up or Down?

Mechanizing
the Hospital

THE AMERICAN HOSPITAL OF PARIS

FIRST IN A SERIES OF ADVENTURES IN HOSPITAL ADMINISTRATION

Transfer your patients
easier, safer on

HAUSTED
"Easy Lift"
Wheel Stretchers!

Now all your patient transfers can be made quickly, safely and without strain on patients or staff, with Hausted "Easy-Lift" Wheel Stretchers.

1. MOVE PATIENT OVER BED

2. TILT PATIENT TO BED

With Hausted "Easy-Lift" stretcher one small nurse can transfer a 300-pound patient by the easy turn of a crank.

Hausted "Easy-Lift" with the exclusive Two-Way Slide and Tilt feature will:

1. ***Move Patient over Bed***
2. ***Tilt Litter so It Locks into Mattress***
3. ***Transfer Patient to Bed without Disturbance***

Thousands of Hausted "Easy-Lift" Stretchers are in daily use in hospitals all over the world. They are engineered for years of hard service. With available accessories, the "Easy-Lift" provides the ultimate in patient care for Emergency and Recovery use.

For complete data on all Hausted Wheel Stretchers, write

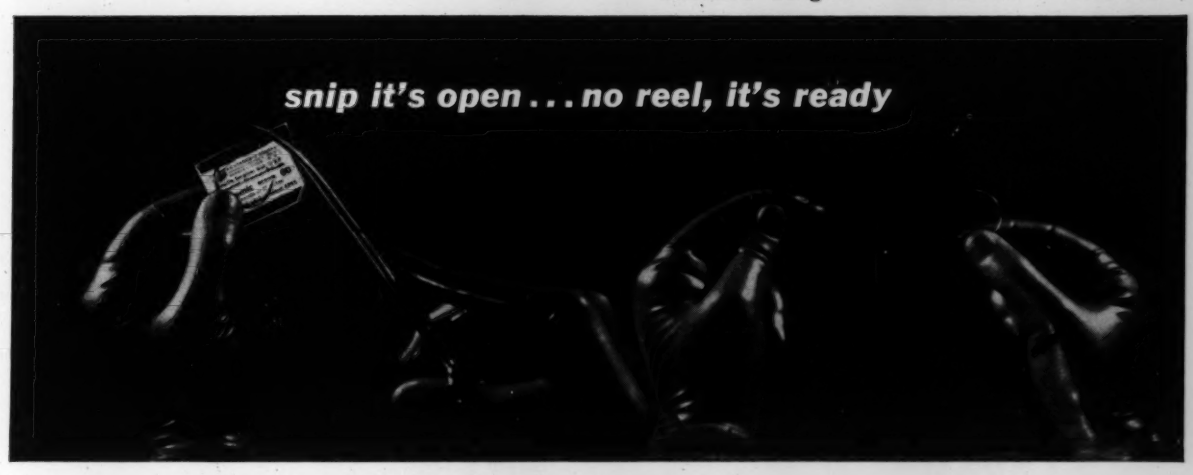
THE
HAUSTED
MANUFACTURING COMPANY
Medina, Ohio

3. PLACE PATIENT ON BED SAFELY

today over 2000 hospitals are saving with

D&G SURGILAR®

Sterile Pack Surgical Gut
Standard Lengths • ATRAUMATIC® Needles



saves 33⅓% preparation time[1]

no more awkward tubes or reels . . . simple technic frees nurses for other duties.

saves broken glass risks

no nicked sutures . . . no glass slivers . . . no punctured gloves . . . nonirritating jar solution – all important contributions to better patient care.

saves suture strength . . . flexibility[1]

no kinks or weak spots from tight reel winding . . . eliminates excessive handling . . . nurse opens sterile sutures as needed to prevent drying out . . . needle points and cutting edges are better protected.

saves dollars[1]

far fewer sutures damaged or opened unnecessarily . . . 30% less glove damage . . . takes half the storage space . . . initial cost, no more than tubes!

1. Alexander, Edythe L.: Mod. Hosp., May, 1957

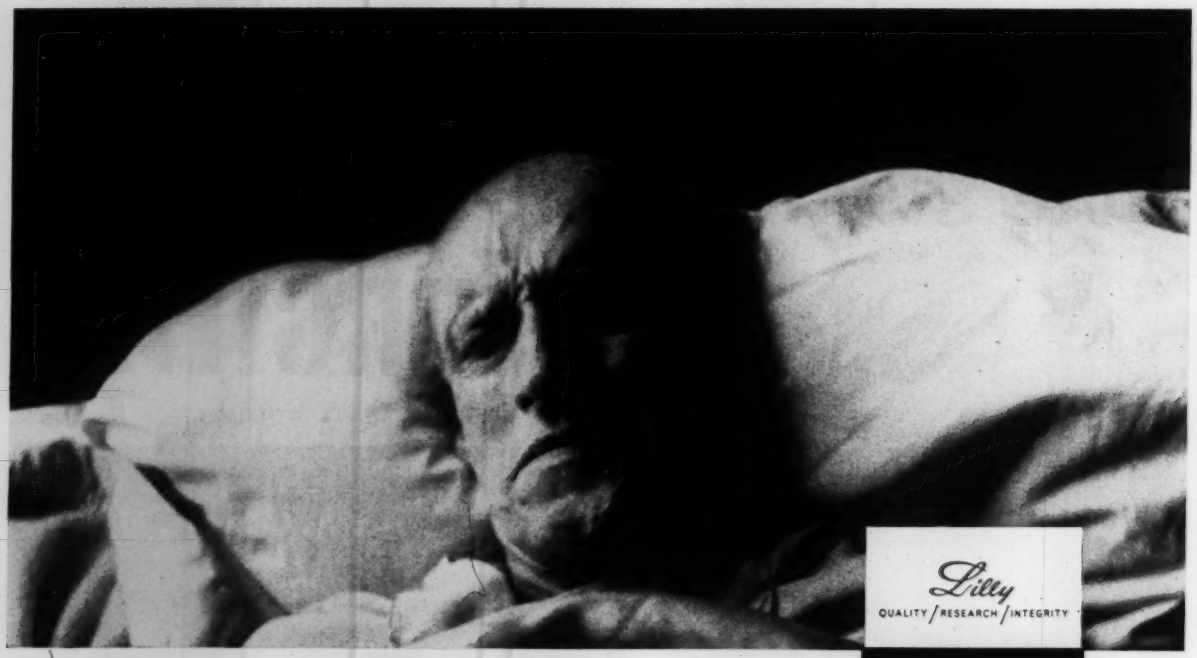
For greatest savings, use the full line of outstanding surgical gut products in hospital-tested SURGILAR sterile packs . . . including –

NEW! D&G Spiral Wound Gut now available in SURGILAR!

Write for new product catalog.

SURGICAL PRODUCTS DIVISION, AMERICAN CYANAMID COMPANY, DANBURY, CONNECTICUT
CYANAMID PRODUCERS OF DAVIS & GECK SUTURES

50 CYANAMID 1907 1957



new non-narcotic analgesic with the potency of codeine

DARVON

(Dextro Propoxyphene Hydrochloride, Lilly)

is the new, chemically different analgesic which is equally as potent as codeine yet much better tolerated.[1] Orally effective, 'Darvon' is valuable in any disease associated with pain. It does not come within the restrictions of the Harrison Narcotic Act.

'Darvon' is available in 32 and 65-mg. pulvules.

DARVON COMPOUND

(Dextro Propoxyphene and Acetylsalicylic Acid Compound, Lilly)

further increases effectiveness by combining the analgesic action of 'Darvon' with the antipyretic and anti-inflammatory benefits of 'A.S.A. Compound.'*

Each Pulvule 'Darvon Compound' provides:

'Darvon'	32 mg.
Acetophenetidin	162 mg.
'A.S.A.' (Acetylsalicylic Acid, Lilly)	227 mg.
Caffeine	32.4 mg.

Supplied in bottles of 100.

**'A.S.A. Compound'* (*Acetylsalicylic Acid and Acetophenetidin Compound, Lilly*)*

1. *Gruber, C. M., Jr.: J. A. M. A., 164:966 (June 29), 1957.*

ELI LILLY AND COMPANY, INDIANAPOLIS 6, INDIANA, U. S. A.

720221

hospitals

journal of the American Hospital Association

volume 31 / *number 22* *november 16, 1957*

editor
Edwin L. Crosby, M.D.

executive editor
James E. Hague

managing editor
Aaron Cohodes

assistant managing editor
Rex N. Olsen

assistant editors
Barbara Elsholz
Eli Fritz
Charlotte M. Roller
Elizabeth Voelker

production manager
Newton J. Jacobson

advertising production manager
Martha E. Miller

controller
John E. Sullivan

circulation supervisor
Dorothy Heller

sales manager
Bremen I. Johnson

sales promotion manager
Hal Levinson

STAFF CONSULTANTS

J. R. Anderson, M.D.
LeRoy E. Bates, M.D.
Arthur H. Bernstein
Robert S. Borczon
Madison B. Brown, M.D.
Jack D. Dillman
Marian L. Fox, R.N.
Hilary G. Fry
Jose Gonzales, M.D.
John N. Hatfield II
Richard L. Johnson
Ruth M. Kahn
John T. Kelly
Edmond J. Lanigan
Catharine H. Loucks
Robert S. Marshall
Helen D. McGuire
Maurice J. Norby
Joseph A. Oddis
Jack W. Owen
David T. Riddell
Daniel S. Schechter
Hiram Sibley
Patricia Sussmann
Elton TeKolste
Alan E. Treloar
Gerald A. Weidemier
Alanson W. Willcox
Kenneth Williamson
Clifford Wolfe
Helen Yast

articles

Bedrails: Up or Down? — James E. Ludlam — 46
The American Hospital of Paris — 48
A 10-Year Look at Uniform Cost Accounting — Fraser D. Mooney, M.D., and Carl M. Metzger — 53
A New Twist in Technician Training — Sister M. Nora, R.N. — 56
Mechanizing the Hospital:
Electric Typewriters Can Save Time and Money — Helen B. Lincoln and Joseph Sherber — 58
Teletype Equipment Can Save Time and Lives — Elton A. Reese — 59
Polling Patients and Personnel, Part 2:
What Factors Affect Patients' Opinions of Their Nursing Care? — Faye G. Abdellah and Eugene Levine — 61
Pneumatic and Vertical Conveyors — John F. Stockwell — 90
What's New in Food Service? — 98

special feature: environmental health and safety

Introduction — Richard G. Bond — 66
A Good Safety Record Calls for Action—and Maybe Money — John Morris — 68
Occupational Hazards That Can Be Overcome — George S. Michaelsen — 72
Radiation—Helpful Friend and Deadly Enemy — Ralph O. Wollan — 76
How To Control Food-Borne Disease in the Hospital — Lee D. Stauffer — 80

regular features and departments

Accreditation Problems — Kenneth B. Babcock, M.D. — 34
American Hospital Association Committees and Appointments for 1958 — 21
Book Reviews — 108
Calendar of Association and Allied Meetings — 6
Digest of News — 17
Editorial Notes — 45
Equipment and Supply Review — 93
Food Service and Dietetics — 98
Introducing the Authors — 12
Law-in-Brief — 110
News — 113
Personnel Changes — 109
Purchasing — 90
Opinions and Ideas — 30
Pro Re Nata — John H. Hayes — 121
Service from Headquarters — 38

cover

The best in French cuisine is not the least of the benefits available to patients at the American Hospital of Paris, Neuilly-sur-Seine, France. A word and picture tour of the hospital begins on page 48. Cover photograph by Russell Melcher—Pix Incorporated. (Other picture credits on page 124.)

Classified Advertising — 122
Index to Advertisers — 124

HOSPITALS is published the first and sixteenth of each month by the American Hospital Association, 18 E. Division St., Chicago 10, Ill. Entered as second class matter January 9, 1936, at the postoffice of Chicago, Ill., under the Act of March 3, 1879. SUBSCRIPTION RATES: $5 for 1 year; $9 for 2 years; $12 for 3 years. Single copies, 30 cents, except the two-part August 1, Guide issue, $2.50. (Foreign and Pan-American add $1 per year for postage.) CHANGE OF ADDRESS: Notice should include the old as well as new address including postal zone number. Four weeks' notice is required. The local postmaster should be notified.

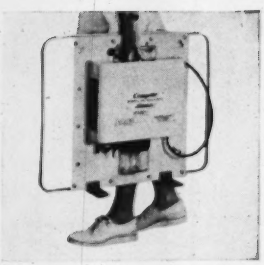
COPYRIGHT: November 16, 1957, by the American Hospital Association.

ADVERTISING REPRESENTATIVES

Chicago 10: *John S. Cassell, 18 E. Division St.—WHitehall 4-4350*
Chicago 10: *William W. Howe, 18 E. Division St.—WHitehall 4-4350*
Cleveland 15: *Eugene C. Leipman, 1220 Huron Rd.—SUperior 1-1373*
New York 22: *George B. Janco, 3 E. Fifty-fourth St.—PLaza 4-1090*
Pasadena: *Ren Averill, 232 N. Lake Ave.—RYan 1-9291*

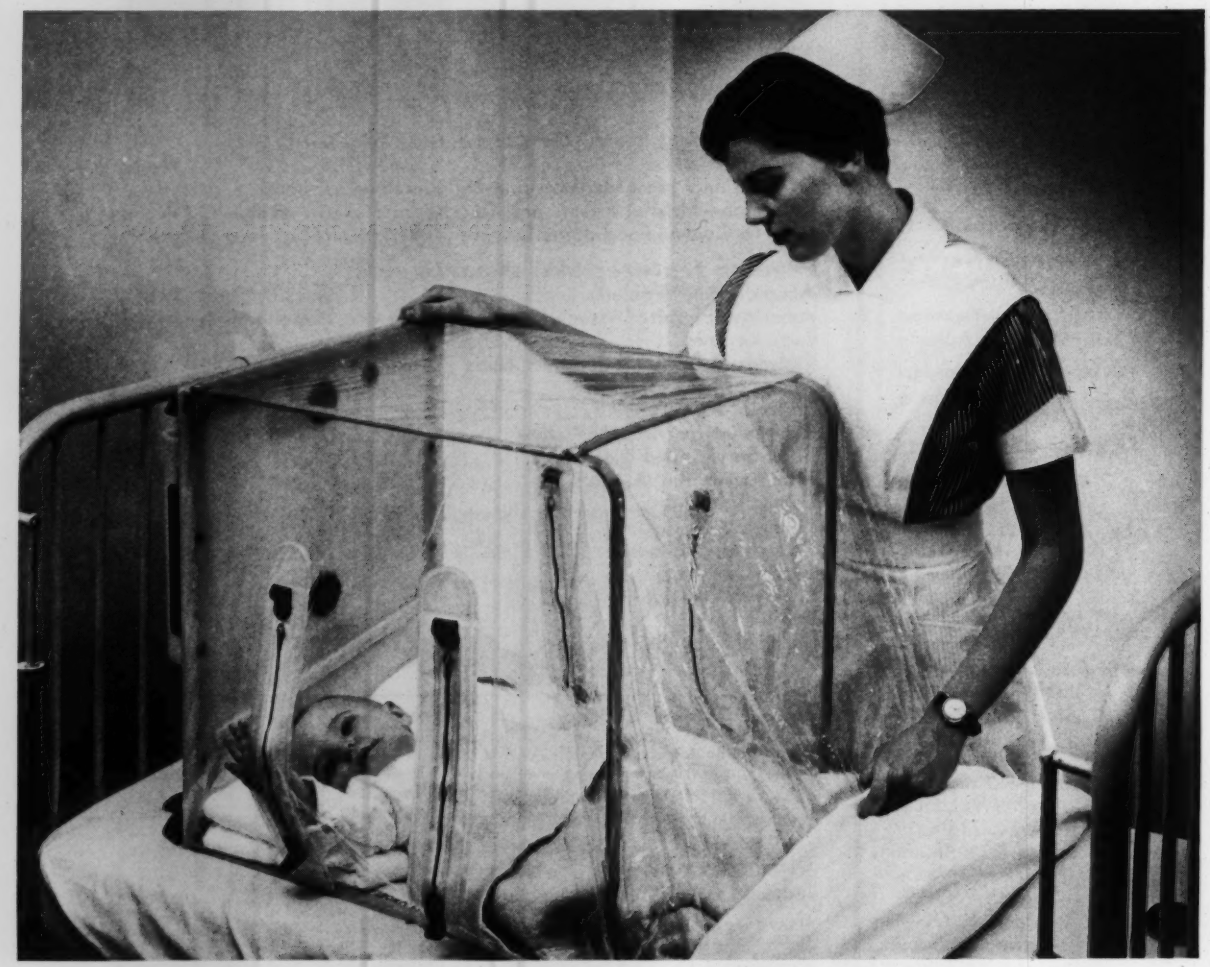
No wonder it's **standard equipment**

The CROUPETTE® is standard equipment in about 3,000 hospitals and 96 per cent of U. S. medical schools. First "cool vapor" croup tent, the CROUPETTE consistently excels all others in comfort, convenience and safety. The fresh, moisture-saturated air is effectively cooled and oxygenated by exclusive CROUPETTE forced circulation. Aerosol or oxygen therapy may be easily administered. With no moving parts, the CROUPETTE is as simple as it is safe and efficient.



Light, compact, portable. Includes spare atomizer.

Visibility and accessibility are CROUPETTE features. Cooled, supersaturated, aerated vapor provides immediate relief and comfort.



The Croupette®

Cool-Vapor and Oxygen Tent By **AIR-SHIELDS, INC.** *Hatboro, Pa. OSborne 5-5200*

For information or orders, call us collect from any point in the U.S.A.

A Stat. Medication

FOR THE PATIENT WITH G.I. DYSFUNCTION
ACCOMPANIED BY LATENT ANXIETY

"Milpath"

Miltown® + anticholinergic

provides "care of the man rather than merely his stomach"

TWO-LEVEL CONTROL OF
GASTROINTESTINAL DYSFUNCTION

at the Peripheral Level...

The tranquilizer Miltown reduces anxiety and tension.[1,3,6,7] Unlike barbiturates, mental and physical efficiency are not impaired.

at the Central Level...

The anticholinergic tridihexethyl iodide reduces hypermotility and hypersecretion. Unlike belladonna alkaloids, dry mouth or blurred vision are rarely produced.[2,4]

INDICATIONS:
Peptic ulcer, spastic and irritable colon, esophageal spasm, G. I. symptoms of anxiety states.

Each "Milpath" tablet contains:
Miltown® (meprobamate Wallace) ..... 400 mg.
(2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate)
Tridihexethyl iodide ..... 25 mg.
(3-diethylamino-1-cyclohexyl-1-phenyl-1-propanol-ethiodide)

Dosage: 1 tablet t.i.d. at mealtime and 2 tablets at bedtime.

Available: Bottles of 50 scored tablets.

References: 1. Altschul, A. and Billow, B.: The clinical use of meprobamate (Miltown®). New York J. Med. 57:2361, July 15, 1957. 2. Atwater, J. S.: The use of anticholinergic agents in peptic ulcer therapy. J. M. A. Georgia 45:421, Oct. 1956. 3. Borrus, J. C.: Study of effect of Miltown (2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate) on psychiatric states. J. A. M. A. 157:1596, April 30, 1955. 4. Cayer, D.: Prolonged anticholinergic therapy of duodenal ulcer. Am. J. Digest. Dis. 1:301, July 1956. 5. Marquis, D. G. Kelly, E. L., Miller, J. G., Gerard, R. W., and Rapoport, A.: Experimental studies of behavioral effects of meprobamate on normal subjects. Ann. New York Acad. Sc. 67:701, May 9, 1957. 6. Phillips, R. E.: Use of meprobamate (Miltown®) for the treatment of emotional disorders. Am. Pract. & Digest Treat. 7:1573, Oct. 1956. 7. Selling, L. S.: A clinical study of Miltown®, a new tranquilizing agent. J. Clin. & Exper. Psychopath. 17:7, March 1956. 8. Wolf, S. and Wolff, H. G.: Human Gastric Function, Oxford University Press, New York, 1947.

WALLACE LABORATORIES New Brunswick, N. J.

hospital association meetings

NATIONAL HOSPITAL ASSOCIATIONS

American Hospital Association

1958 Annual Convention—August 18-21; Chicago (Palmer House; International Amphitheatre)

1959 Annual Convention—August 24-27; New York City (Coliseum, Statler Hotel)

1960 Annual Convention—August 29-September 1; San Francisco (Civic Auditorium)

(THROUGH OCTOBER 1958)

Midyear Conference of Presidents and Secretaries — February 7-8; Chicago (Palmer House)

American Protestant Hospital Association —February 11-13; Chicago (Morrison Hotel)

Catholic Hospital Association—June 21-26; Atlantic City, N. J. (Dennis Hotel; Convention Hall)

REGIONAL MEETINGS

(THROUGH OCTOBER 1958)

Association of Western Hospitals—April 21-24; San Francisco (St. Francis Hotel; Civic Auditorium)

Carolinas-Virginias Hospital Conference —April 24-25; Roanoke, Va. (Hotel Roanoke)

Middle Atlantic Hospital Assembly — May 21-23; Atlantic City, N. J. (Convention Hall)

Mid-West Hospital Association — March 24-26; Kansas City, Mo. (Municipal Auditorium)

New England Hospital Assembly—March 24-26; Boston (Statler Hotel)

Southeastern Hospital Conference—May 14-16; Miami Beach, Fla. (Hotel Fontainbleau)

Tri-State Hospital Assembly—April 28-30; Chicago (Palmer House)

Upper Midwest Hospital Conference — May 14-16; Minneapolis (Minneapolis Auditorium)

STATE AND PROVINCIAL MEETINGS

(THROUGH APRIL 1958)

Alabama Hospital Association—January 30-31; Tuscaloosa (Hotel Stafford)

Arizona Hospital Association — December 5-6; Phoenix (Hotel Westward Ho)

Georgia Hospital Association—February 20-21; Columbus (Ralston Hotel)

Illinois Hospital Association — December 5-6; Springfield (Abraham Lincoln Hotel)

Kentucky Hospital Association — April 15-17; Louisville (Sheraton-Seelbach Hotel)

Louisiana Hospital Association — March 20-22; Baton Rouge (Bellemont Motor Hotel)

Ohio Hospital Association — March 10-13; Cincinnati (Netherland-Hilton Hotel)

Wisconsin Hospital Association—March 13; Milwaukee (Hotel Schroeder)

AHA INSTITUTES

(THROUGH APRIL 1958)

Seventh Hospital Institute — November 18-22; Honolulu, Hawaii (Reef Hotel)

Hospital Safety Seminar—November 18-22; Chicago (Congress Hotel)

"Staffing" Department of Nursing Institute — December 9-12; New York City (Sheraton-McAlpin Hotel)

Planning a Personnel Development Program — December 9-13; Chicago (Edgewater Beach Hotel)

Directors of Hospital Volunteers—January 14-16; San Francisco (St. Francis Hotel)

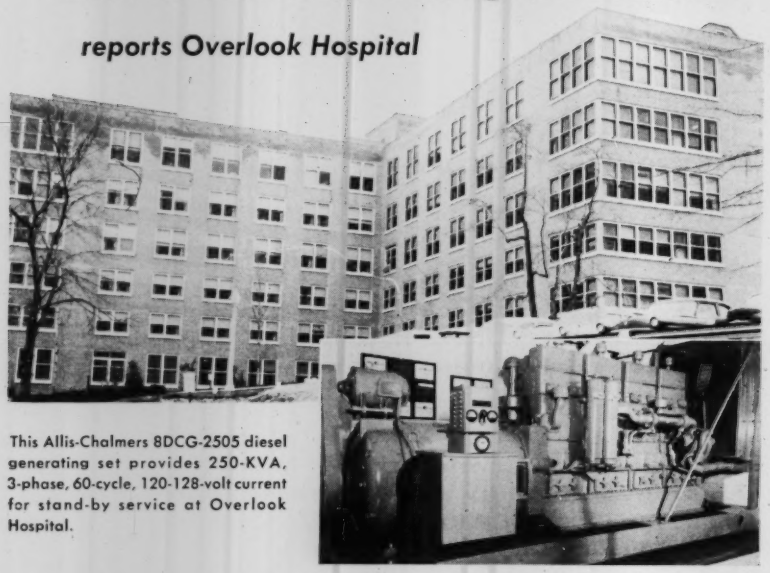
Dietary Department Administration — January 20-24; Dallas, Tex. (Adolphus Hotel)

Institute for Nurse Anesthetists — January 20-24; Omaha, Nebr. (Sheraton-Fontenelle Hotel)

As soon as determined, notice of your annual meeting at which officers are elected, should be mailed to the editors of HOSPITALS, J.A.H.A., 18 East Division Street, Chicago 10, Illinois.

ALLIS-CHALMERS GENERATING SET
"carries full load with good results"

reports Overlook Hospital



This Allis-Chalmers 8DCG-2505 diesel generating set provides 250-KVA, 3-phase, 60-cycle, 120-128-volt current for stand-by service at Overlook Hospital.

A continuous source of electricity for Overlook Hospital, Summit, New Jersey, is assured since an Allis-Chalmers 200-kw diesel generating set was installed.

A spokesman for the hospital reports that this unit has "carried the full load of the hospital with good results" — 6 diagnostic X-ray units and 2 therapy units, 4 elevators, 40-ton air conditioning unit, 15 individual window air conditioners and 125 electric motors ranging from ½ to 40 hp — plus small electric heaters, wall fans, etc. The load the generating set will carry will be greater as the size of the hospital is increased from its present 250 beds.

If you are building, modernizing or enlarging your hospital, get all the facts on Allis-Chalmers engine generating sets whether your need is for stand-by or continuous power. The Allis-Chalmers reputation for building engines and electrical equipment of outstanding quality, the wide range of sizes . . . 5 to 300 kw with choice of fuels, the outstanding service — these are your assurance of installations that will exactly serve your needs.

For complete service... including planning, installation and operational service . . . call your Allis-Chalmers engine dealer or write for detailed information.

ALLIS-CHALMERS, BUDA DIVISION, MILWAUKEE 1, WISCONSIN

ALLIS-CHALMERS

BG-18

new from BLICKMAN!

self-propelled TOUCH-N-GO Foodveyor*

Now tiniest dietary aides take heaviest-loaded food conveyors anywhere! New safety!

Touch the button as you walk ahead. The Blickman "Touch-n-Go" Foodveyor follows behind you, *under its own power*. In and out of elevators, around corners, up and down hospital ramps, now female dietary aides can take heaviest-loaded food conveyors anywhere!

Simple and instantaneous Blickman "Touch-n-Go" power drive has thumb-button controls recessed in steering handle.

Safer than any other conveyor made! Look at these safety advantages you get only with Blickman "Touch-n-Go" Foodveyor!

- Operator walks *ahead* of Foodveyor! For the first time, operator has unimpeded vision and cannot "run down" obstacles—because she doesn't *push*, she *leads*, and conveyor follows behind.
- Controlled speed—foodveyor cannot run away, even holds back on ramps. Slow forward speed for safety. Quarter-speed reverse!
- *Instant response* when thumb presses button.
- *Instant power brake* acts the moment thumb is taken off button. *"Touch-n-Go" Foodveyor stops in inches even on ramps!*

Full clearance under conveyor—vital for elevators, ramps, doorsills.

Less labor, less muscle. Each Foodveyor takes heavier load, speeds service, reduces number of trips. Eliminating duplication of personnel, the "Touch-n-Go" reduces hospital dependence on custodial labor.

Let us show you how the Blickman "Touch-n-Go" Foodveyor pays for itself! Ask about our plan for try-out *in your hospital* ...no obligation, of course. See your Blickman dealer, or write S. Blickman, Inc., 3811 Gregory Avenue, Weehawken, New Jersey.

VISIT OUR BOOTH AT:
NATIONAL HOTEL SHOW
N. Y. Coliseum, N. Y. C.
Nov. 11-15, Booth #2178

BLICKMAN FOOD SERVICE EQUIPMENT

Look for this symbol of quality — Blickman-Built ESTABLISHED 1884

"Mediatric" will help make the "senior" years more pleasant and enjoyable.

"Mediatric" is specially formulated to counteract the adverse influence of declining gonadal function, nutritional inadequacy and emotional instability.

"Mediatric" contains estrogen and androgen in amounts that will effectively supplement reduced gonadal hormone production; nutritional supplements carefully selected to meet the needs of the patient; and a mild antidepressant to promote a brighter mental outlook. Available in tablets, capsules, and liquid.

"MEDIATRIC"®

Steroid-Nutritional Compound

IN PREVENTIVE GERIATRICS

Ayerst

Ayerst Laboratories • New York, N. Y. • Montreal, Canada

BE SAFE

BE SURE

specify

CONDUCTILE CONDUCTIVE VINYL FLOORING

1 FACTORY GUARANTEED

KNOW your operating room floors are RIGHT . . . the finished installation is tested and guaranteed BY THE FACTORY to meet all National Fire Protection Association and National Bureau of Fire Underwriters requirements for 5 full years!

2 FACTORY CONTROLLED

Every tile is individually tested for conductivity at the factory . . . installed ONLY under the supervision of factory-trained personnel.

3 NO DISRUPTIONS

CONDUCTILE can be installed without interfering with your surgical schedule . . . overnight, in most cases . . . with minimum muss and fuss.

. . . made only by
VINYL PLASTICS INC.

SHEBOYGAN, WISCONSIN

H117

PLEASE SEND FULL STORY NOW!

We would like full details on CONDUCTILE conductive vinyl flooring for our operating rooms and adjacent areas.

NAME.....

HOSPITAL.....

ADDRESS.....

ST. JOHN'S HOSPITAL, SPRINGFIELD, MISSOURI

A hospital with suddenly would certainly have to

"Hospitals are, in themselves, models of technical excellence and operating efficiency. So you can easily imagine the chaos that suddenly interrupted elevator service would create.

"ST. JOHN'S HOSPITAL has eight floors: basement, ground, 1, 2, 3, 4, 5 and 6, with six operating rooms on the second floor. Our staff numbers 130 doctors, 400 workers, 100 student nurses and 23 nuns. You can see that it is not possible to overemphasize the importance of elevators in an institution of our size.

"That's why we have depended entirely and confidently upon complete OTIS Maintenance for our 4 passenger, 3 service and freight elevators, as well as our 6 dumbwaiters, since 1952. In old ST. JOHN'S HOSPITAL, here in Springfield, we've had OTIS Maintenance on 2 Elevators since 1937.

"Our OTIS contract provides for systematic examinations at regular intervals including lubrication, necessary adjustments and cleaning of the equipment and the repair and replacement of any part large or small made necessary by the wear of normal operation. Only genuine OTIS parts are used for replacements. For this service we pay a flat monthly charge which we can easily budget. There are no 'extras' for repairs or emergency service.

"We're actually assured of peak performance elevator service at all times."

"ENGINEERED SERVICE BY THE MAKER"

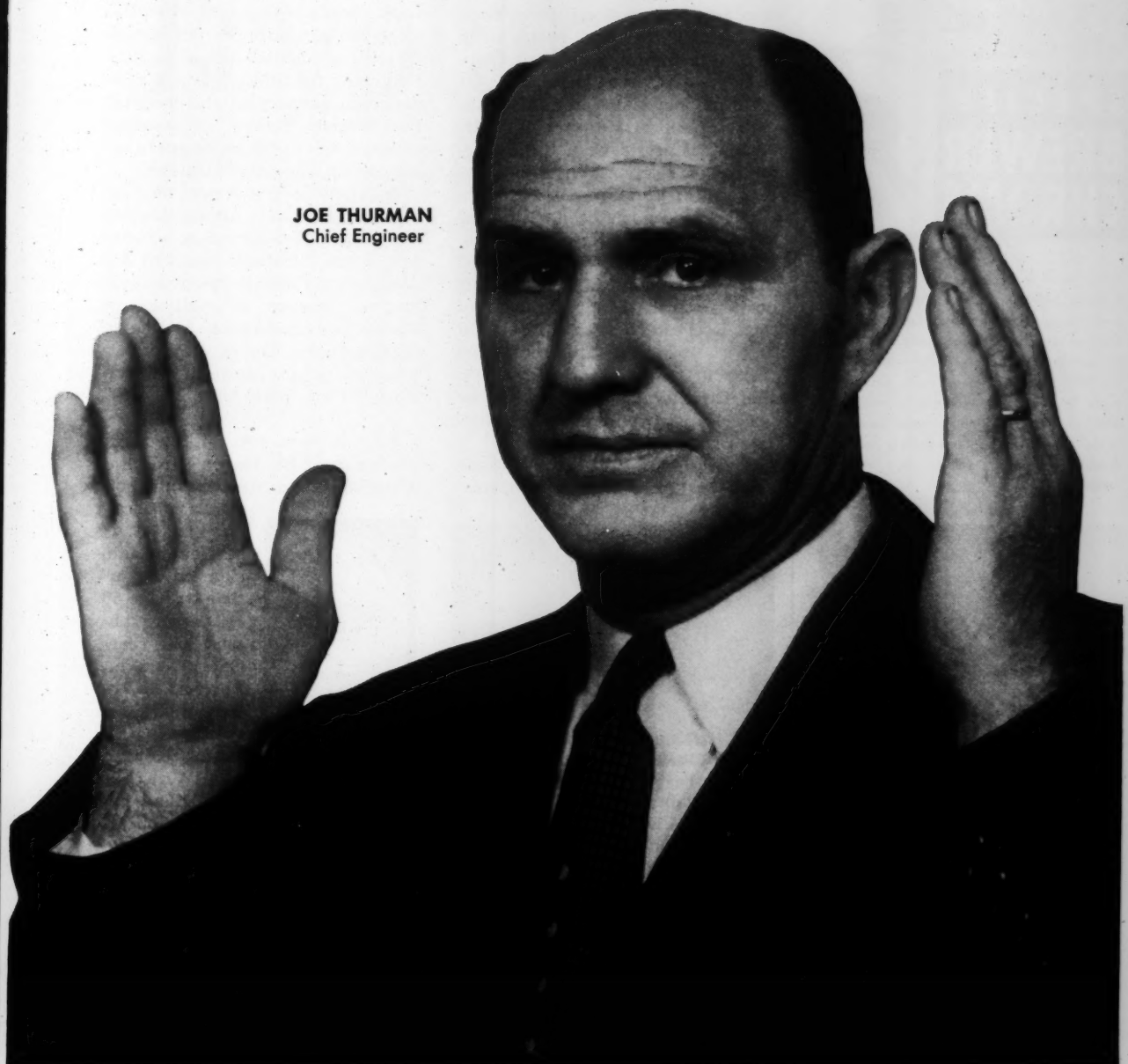
Otis

elevator

THAT KEEPS ELEVATORS

OTIS ELEVATOR COMPANY • 260 ELEVENTH AVENUE • NEW YORK 1, N. Y.

interrupted elevator service
be placed on the "critical list"



JOE THURMAN
Chief Engineer

maintenance

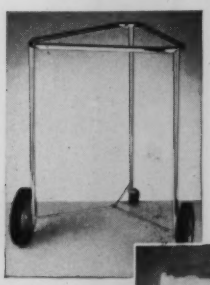
RUNNING LIKE NEW

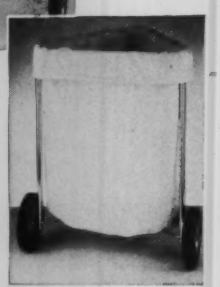
Budget Wise Buyers

SPECIFY BREWER CHROME

First BREWER

Want more for your dollar? Then specify lustrous BREWER Chrome Plated hospital and surgical equipment. Costs only a fraction of conventional equipment, with no sacrifice of beauty, utility, durability. All BREWER units come "clean and complete in the carton"—ready to use! The BREWER CHROME line includes hampers, carts, tables, stools, commodes, solution stands, instrument stands, and related items.





No. 1346, Triangular hamper, with 2 large wheels and one small caster. Takes standard 25" bag.

This hamper is a typical example of how BREWER designs products to meet your needs. Triangular shape means easier storage. 2 Large rubbertired wheels ride easier over obstacles. Hamper may be tilted, wheelbarrow fashion, for quicker movement, sharper turns.

*AVAILABLE FROM YOUR HOSPITAL SUPPLY DEALER

MFD. By E. F. BREWER CO. • Butler, Wis.

introducing the authors

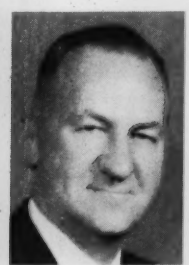
Frazer D. Mooney, M.D., and **Carl M. Metzger** evaluate the uniform cost accounting system used during the past decade in western New York by Blue Cross and cooperating hospitals in determining reimbursement rates on page 53.

Dr. Mooney is director of Buffalo (N.Y.) General Hospital and Mr. Metzger is president of the Hospital Service Corporation of Western New York, Buffalo.

Mr. Metzger has been associated with the western New York Blue Cross plan since it was organized in 1936. At that time he left his position as assistant director of the Rochester (N.Y.) Hospital Service Corporation to become the plan's first director. He served in that capacity until 1954 when he was elected president of the Buffalo plan.

Prior to his Blue Cross affiliations, Mr. Metzger was associated

DR. MOONEY



MR. METZGER

for a number of years with Yawman and Erbe Manufacturing Company, Rochester, N. Y. He served as systems and efficiency expert and conducted research in the field of criminal identification systems. Mr. Metzger was largely responsible for many of the classifications for indexing systems for recording finger prints and criminal histories that are used by police departments and the Federal Bureau of Investigation.

Currently chairman of the Blue Cross Commission technical advisory committee, Mr. Metzger was treasurer of the commission during 1954-55. He has also served as chairman of the commission's underwriting committee as well as a member of the executive and national activities committees of the Blue Cross Commission.

Dr. Mooney has been associated with Buffalo General Hospital since his graduation from McGill University Medical School in 1924. Following his internship and residency in surgery at the hospital, Dr. Mooney served as assistant superintendent for three years before being appointed director.

A fellow in the American College of Hospital Administrators, Dr. Mooney has served as a member of the American Hospital Association's Council on Administrative Practice as well as its Committee on Hospital Architects' Qualifications. He is also a past president of the Hospital Association of New York State.

Sister M. Nora, R.N., supervisor in obstetrics at St. Joseph's Hospital, Memphis, Tenn., describes the hospital's program for training surgical technicians in her article on page 56.

SISTER NORA

During the past four years, Sister Nora has concentrated her attention on training programs for practical nurses, nurse aides and technicians. She has been an instructor in obstetric and pediatric nursing for a number of years as well as director of St. Anthony Hospital School of Nursing, Terre Haute, Ind.

A member of the National League for Nursing, Sister Nora is currently treasurer of District I of the league. She also holds membership in the American Nurses' Association.

A graduate of Lutheran Hospital School of Nursing, Cleveland, Sister Nora is currently registered in Tennessee, Ohio, Nebraska, and Indiana. She received her B.S. degree in nursing from Creighton University, Omaha, Nebr., and a master's degree in education from Loyola University, Chicago.

Tryptar®

within minutes . . .

starts cleaning a wound

of tissue debris

INDICATIONS:

varicose ulcers
abscesses
wounds
carbuncles
furuncles
decubitus ulcers
gangrene
osteomyelitis
sinuses
fistulas
ulcerations
diabetic ulcers
second and third degree burns
infected compound fractures
necrotic lesions due to peripheral vascular disease
amputation stumps

Tryptar digests any fibrinous, purulent or gangrenous tissue.

Tryptar is *long-acting*. It provides tryptic activity up to 72 hours, making it *practical* and more economical. Tryptar is *stable* after preparation for at least 72 hours if refrigerated. It is stable indefinitely in dry form.

Tryptar is safe. It won't harm living tissue. It may be used topically in the powder form, as a wet dressing, or infiltrated. It may also be used as an aerosol for inhalation therapy.

CONTRAINDICATION: Severe hepatic insufficiency. Not for intravenous use.

SUPPLIED: in 3 convenient strengths: 50,000, 125,000 and 250,000 Armour units of purified crystalline trypsin.

THE ARMOUR LABORATORIES
A DIVISION OF ARMOUR AND COMPANY · KANKAKEE, ILLINOIS

NEW SIM-MATIC ALL-MOTORIZED BED
GIVES NEW FREEDOM TO NURSE AND PATIENT

With the new Sim-Matic bed, you change the position of the head or knee sections of the spring, or change bed height—all with one compact, hand-held control.

The patient doesn't need to call the nurse for a slight change in posture. She makes the change herself—safely and gently. When it is necessary for the nurse to operate the bed, she does so without cranking or stooping. She just uses the hand-held control. Operation of head and knee sections of the spring can be taken out of the patient's control by cutoff switches. In case of power failure, a hand crank is provided to operate the spring. In addition, head or foot ends of the bed can be power operated independently to achieve quick Trendelenburg or Fowler positions.

The completely enclosed ¼ horsepower motor is instantly reversible and has built-in protection in the form of a thermal cut out that automatically stops it in case of overload or overheat. A powerful capacitor stores power so less current is required to start the motor. Lower amperage means more beds can be operated on one line.

Write for Simmons new Hospital Catalog #29 for complete information on Sim-Matic and other Simmons products for modern hospitals.

The nurse can control operation of the new Sim-Matic motorized Vari-Hite bed without stooping or bending. The hand-held control (inset) is visible at all times.

SIMMONS COMPANY

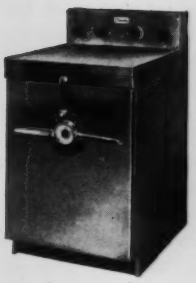
DISPLAY ROOMS:
Chicago 54, Merchandise Mart • New York 16, One Park Avenue
Columbus 8, 1275 Kinnear Road • San Francisco 11, 295 Bay St.
Atlanta 1, 353 Jones Ave., N.W. • Dallas 9, 8600 Harry Hines Blvd.
Los Angeles 22, 3217 S. Garfield Ave.

Now ...a Better Technique for Patient Utensils

the *American* UTENSIL WASHER -SANITIZER

The American Utensil Washer-Sanitizer provides efficient equipment to carry out an improved technique in preventing the transfer of communicable diseases among patients and hospital personnel. Convenient and automatic, it washes and sanitizes three full sets of patients' utensils in two loads . . . at a speed well within the normal discharge-and-admission rate. Simple and economical to install and operate, the Washer-Sanitizer saves personnel time, reduces utility room clutter and assures uniform cleaning and sanitizing at less cost.

For complete information on this new Utensil Technique, write for bulletin SC-321.



• The American Utensil Washer-Sanitizer is available with stainless steel utility room clean-up counter or as the free-standing unit shown above.

AMSCO

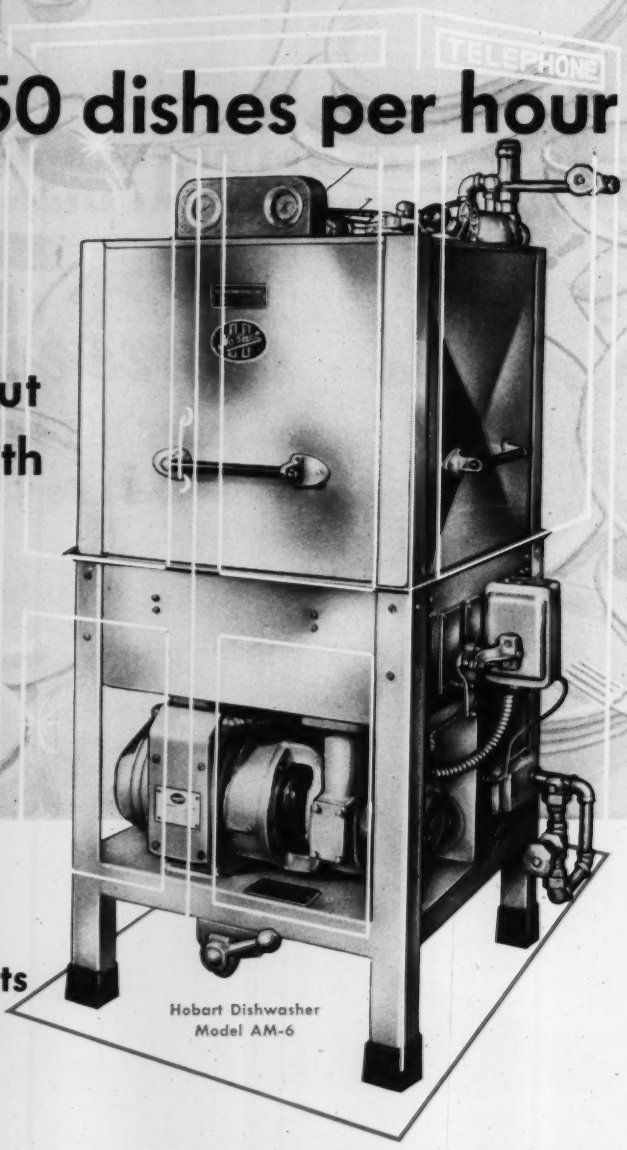
AMERICAN STERILIZER

ERIE • PENNSYLVANIA

Offices in 14 Principal Cities

Cleans up to 1250 dishes per hour

...from floor space about the size of a Phone Booth



Hobart Dishwasher
Model AM-6

Versatile Hobart AM Design Gets the Call—from Near and Far

Here's the kitchen work-horse unchallenged for leadership in the whole world-wide dishwashing field. With output of 50 racks, 1250 dishes or 2250 glasses per hour, it's most widely used in small-to-medium range kitchens—or as a peak-load glasswasher in larger operations. And you get all this output—Hobart standard—from less than 2½ feet square of machine (plus dish table layout, of course).

Whatever your layout—or requirements—the AM design fills the bill. You can buy it in 2-door models for straight-through use—in 3-door models for corner use—with and without automatic timing plus various interlocks—single operating lever actuating thermal overload switch—and a host of other features.

Whatever the size Hobart unit or application, you *always* get the high-speed wash powered by a Hobart-built motor, the high efficiency pump, the exclusive revolving wash system. That's Hobart standard—for the finest wash-rinse system you can buy.

If your capacity is more or less, there's just the model for you in the greatest line in the entire industry. See Hobart now . . . ***The Hobart Manufacturing Co., Troy, Ohio.***

Trademark of Quality Hobart for sixty years

Hobart
machines

The World's Largest Manufacturer of Food, Kitchen and Dishwashing Machines

THE HOBART MANUFACTURING COMPANY,
Dept. ADV. Troy, Ohio

Please send me your illustrated brochures on these products.

- ☐ HOBART DISHWASHERS AND GLASSWASHERS
- ☐ HOBART FOOD MACHINES
- ☐ HOBART KITCHEN MACHINES

NAME_____ TITLE_____

COMPANY NAME_____

ADDRESS_____

CITY_____ ZONE_____ STATE_____

REPORT FROM WASHINGTON—President Eisenhower, in an address before the National Fund for Medical Education, called for greater expenditures for medical schools by industry and the general public and a curtailment of federal activity in this area.

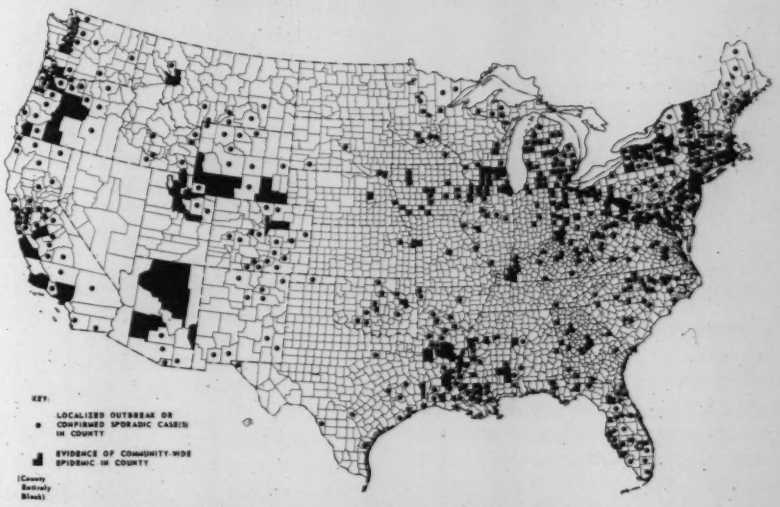
The President praised corporate support of medical education, citing contributions which exceeded $100 million in 1956. He said, however, that medical schools need an additional $10 million per year to balance their budgets and that the problems which medical schools face will become greater as the population continues to expand. Details p. 113.

RED CROSS OUTLINES EMERGENCY FLU PREPARATIONS—The American National Red Cross has announced that its chapters are accelerating their present programs so that they may be incorporated into community plans against the threat of an Asian influenza epidemic.

ARC stated that these are the ways that the chapters are preparing in their communities:

- Through assignment of professional nurses already enrolled by the Red Cross to serve where needed during this emergency. More than 50,000 nurses are enrolled, many of them on duty regularly in Red Cross blood programs
- Through a continuous program of classes in care of the sick and injured—a 14-hour course in home nursing.
- Through a 40-hour course for volunteer nurse's aides who are trained to assist nurses in hospitals and clinics. Since 1935 some 250,000 volunteer nurses' aide certificates have been issued; these workers will be available to assist hospitals, if needed.
- Through the enrollment of other trained Red Cross volunteers to assist with community-wide plans for combating the epidemic. Motor, canteen, Gray Lady, and production services will be available to help transport patients to and from hospitals and clinics, assist in the preparation of meals and in the making of supplies such as surgical dressing and face masks.

PHS Reports on Asian Influenza


KEY:
LOCALIZED OUTBREAK OR CONFIRMED SPORADIC CASE(S) IN COUNTY
EVIDENCE OF COMMUNITY-WIDE EPIDEMIC IN COUNTY
(County Entirely Black)

THIS MAP indicates the incidence of Asian influenza in the United States on a county by county basis, as compiled by the Public Health Service effective Oct. 27. The size of the black area indicates the geographical area of the county or counties where there is a high incidence of flu rather than how great that incidence is. Approximately 500 deaths in this country have been attributed to complications arising from attacks of Asian influenza virus.

AMERICAN HOSPITAL ASSOCIATION HEADQUARTERS BUILDING—Construction of the new 12-story AHA headquarters building in Chicago is in full swing. Details p. 116.

ANESTHESIOLOGISTS' CONVENTION—Use of a postanesthetic observation room immediately following surgery was advocated in an address presented at the American Society of Anesthesiologists convention. Details p. 116.

PHILADELPHIA OCCUPANCY RATE DOWN LAST SUMMER—Fifty-two Philadelphia area hospitals reported that during the quarter ended Aug. 31 their total occupancy rate was 74.2 per cent. This is the lowest quarterly rate reported by these hospitals in 21 months. Details p. 117.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION CONVENTION—Details p. 19.

COLLEGE OF ADMINISTRATORS OUTLINES TWO NEW PROGRAMS—Details of two new programs have been announced by the American College of Hospital Administrators.

Scheduled for Dec. 2-6 in Los Angeles is the First Western Advanced Institute which the college is sponsoring in cooperation with the Association of Western Hospitals, California Hospital Association, and the Hospital Council of Southern California.

Worth Quoting

". . . Price tags do not produce income. Hospital charges should encourage high professional standards and optimum use of facilities and personnel. Relatively high room rates tend to shorten periods of stay. Relatively low special service charges encourage good diagnosis and treatment. A hospital collects money in order to provide care; it doesn't provide care in order to collect money . . ."—C. Rufus Rorem, Ph.D., *executive director, Hospital Council of Philadelphia, in the council's newslettter, February 1957.*

Featured at the institute will be a workshop on current problems in hospital administration and a conference on human relations.

The college has also announced the appointment of a nine-man committee to develop the educational program for the first Congress on Administration.

The congress, to be presented in commemoration of the college's 25th anniversary, is scheduled for Feb. 9-11, 1958, in Chicago.

Ray E. Brown, superintendent of the University of Chicago Clinics, is head of the program committee. Further information on both the institute and congress may be obtained from ACHA, 620 North Michigan Ave., Chicago.

DIETITIAN RECRUITMENT GRANT ANNOUNCED AT ADA CONVENTION—Announcement of a $25,000 grant for production of a recruitment film in the field of hospital dietetics climaxed the 40th annual meeting of the American Dietetic Association in Miami, Fla., last month.

In making the announcement at the association's banquet, B. D. Graham, vice president of H. J. Heinz Co., said the motion picture is designed to alert young people to the opportunities in dietetics and thereby reduce the "acute and growing shortage of hospital dietitians." He said they had been alerted to this need by the American Hospital Association and the American Dietetic Association.

Lucille M. Refshauge, ADA immediate past president, reported earlier that "three out of five hospitals in the United States today are without qualified dietitians."

Miss Refshauge also stated that "although hospitals are growing in number and in patient load, only 600 dietetic interns are preparing annually for careers in dietetics, whereas 15 years ago more than 900 young people completed internships each year."

A professional film-making organization will produce the motion picture. The producers will be advised by a four-member committee composed of: Doris Johnson, Ph.D., director of dietetics, Grace-New Haven (Conn.) Community Hospital; Madge Myers, director of dietetics, Peter Bent Brigham Hospital, Boston; Thelma Pollen, public relations director, American Dietetic Association, Chicago, and Margaret Murray Hinkle, dietitian in charge, Columbus Receiving Hospital and State Institute of Psychiatry, University Health Center, Columbus, Ohio.

Other highlights of the banquet were the installation of new officers and presentation of awards. E. Neige Todhunter, Ph.D., dean, School of Home Economics, University of Alabama, was installed as president, succeeding Miss Refshauge. President-elect is LeVelle Wood, chairman, Division of Institution Management, School of Home Economics, Ohio State University.

Other new officers are: speaker of the house of delegates, Geraldine M. Piper, regional nutrition consultant, Public Health Service, Charlottesville, Va.; secretary, Helen H. Anderson, director of dietetics, Stanford University Hospitals, San Francisco, and treasurer, Frances L. Low, director of dietetics, Methodist Hospital, Houston, Tex.

Two dietitians from Chicago's Presbyterian-St. Luke's Hospital were recipients of awards presented at the banquet. Anna Boller Beach, director of the nutrition clinic, received the Marjorie Hulsizer Colpher Award in recognition of distinguished service to the dietetic profession.

MISS TODHUNTER

MISS WOOD

Mrs. Beach was the first executive secretary of ADA and has held the elected offices of president and treasurer. The Lydia J. Roberts Essay Award was presented to Winifred M. Ayers, nutritionist at Morton Clinic of Presbyterian-St. Luke's. The award, made by the Gerber Products Co. for the past several years, is given to the writer of the best essay on a given subject.

Other aspects of the ADA meeting appear on page 98.

TWO-YEAR SCHOOL SEEN AS AID IN INCREASING DOCTOR SUPPLY—Two-year preclinical medical schools should be established at universities without medical colleges in an effort to increase the number of physicians in this country. This was the statement made in a resolution passed by the Association of American Medical Colleges at its 68th annual meeting last month.

The association took note of the fact that four more medical schools are being added to the list of approved educational institutions and that there will be an increase of approximately 7400 medical graduates during the next seven years. This increase, however, it was further stated, will not keep pace with the expanding health needs of the country.

Existing four-year medical schools can, because of failures and dropouts during the first two years, absorb 400 additional students a year in their third and fourth year programs, an association spokesman stated.

"If this number of students were progressing from new two-year programs fully integrated on the one hand with the undergraduate college program and on the other hand with existing four-year schools, our annual number of medical graduates would be increased significantly," the association's resolution read.

In another area, AAMC declared itself as favoring federal assistance in the construction, expansion, and modernization of old and new medical schools. (Also see the Washington Report, beginning on p. 113.)

Speakers at the Atlantic City, N.J., convention advocated that medical students be given more opportunities to do research work and that they should get more training in the field of mental health.

AAMC officers for 1958 are: president, Dr. Lowell T. Coggeshall, University of Chicago School of Medicine; president-elect, Dr. John McK. Mitchell, University of Pennsylvania Graduate School of Medicine; vice president, Dr. Joseph Wearn, Western Reserve University School of Medicine, and treasurer, Dr. Stockton Kimball, University of Buffalo School of Medicine.

MD.-D.C.-DEL. ASSOCIATION CONVENTION—

Hospitals' Responsibilities Examined

"Responsibility"—both hospitals' responsibilities to their communities and the many responsibilities within hospitals themselves—was the theme of the 17th Annual Conference of the Maryland-District of Columbia-Delaware Hospital Association held Nov. 6-8 in Washington.

In an address before the conference general session, Dr. Edwin L. Crosby, American Hospital Association director, declared that hospitals are not controlled by professionals but by the community leaders who compose the 50,000 hospital trustees across the country.

It is these trustees, and the time they so freely give, that has placed responsibility for community health care with the public itself, Dr. Crosby said. The result is the present high position held by community hospitals in America, he added.

Developing the convention keynote of responsibility, Walter J. McNerney, program director in hospital administration, University of Michigan, emphasized that a hospital's responsibility is to many public communities. He said that too often administrators think of the public as a single entity, when actually it is made up of many isolated groups to which the hospital's responsibility must be individually adapted.

TRUSTEE'S VIEWPOINT

Speaking as a trustee at a panel on "the administrator's responsibility," Anson B. Nixon, president of the Wilmington (Del.) General Hospital, named the administrator's most important responsibility as "welding of a team" within the hospital. He said that praise should be given to all team members even though they are merely living up to their responsibilities. It is this praise which keeps them on the team," he declared. Inclusion of the patient on the team was also stressed. "We need the patient's help and understanding," he said.

Mr. Nixon also told the panel that "we know that the board of trustees can only create more problems than it resolves if it undertakes to come between the administrator and his people."

Mr. Nixon is a board member and retired chairman of the Hercules Power Co., Wilmington.

In a talk before the same panel, Ray E. Brown, Superintendent, University of Chicago Clinics, and a past president of AHA, outlined three major areas of responsibility for the administrator — efficiency, solvency, and willingness to change. Hospitals must be considered as a business enterprise, he said, and they exist "in an economy where the store is kept in terms of dollars and cents."

As the medical staff member before the panel, Dr. Edward S. Stafford, associate professor of surgery, Johns Hopkins University School of Medicine, declared that under the "unique" type of institutional organization in a modern hospital, the relationship of the administrator to the professional staff can be subdivided into three categories:

1. Those over which the administrator should have "undisputed control."

2. Those which should be the sole concern of the professional staff.

3. Those which should be the joint responsibility of both.

Dr. Stafford said that this division involved some "highly controversial points" that can be resolved by giving the welfare of the patient first consideration.

Dr. Crosby also reported on new AHA programs planned to help regional, state, and municipal hospital associations. He termed these new services an "invitation" to the grass roots and not an invasion of local functions. Health care of the aged and the national shortage of nurses were named by Dr. Crosby as the two major problems confronting hospital associations this year. He reported that in order to move forward on these and other basic health needs AHA has organized a new hospital research and trust foundation with $3.2 million in funds available.

POISON CONTROL CENTERS

Two speakers before a symposium of Maryland-District of Columbia-Delaware pharmacists urged hospital staffs to take the lead in promoting the establishment of more poison control centers.

In one address, Dr. Irvin Kerlan, chief, research and reference branch, Bureau of Medicine, Food and Drug Administration, reported that about 100 poison control centers have already been set up throughout the United States.

Dr. Robert H. Parrott, physician in chief, Children's Hospital, Washington, told the meeting that of the estimated 2000 deaths each year in the United States from accidental poisoning, the largest

NEWLY elected officers of the Maryland-District of Columbia-Delaware Hospital Association are (back row, l to r): first vice president, Sanford Kotzen, administrator, Franklin Square Hospital, Baltimore; secretary, M. B. Tuttle, administrator, Montgomery General Hospital, Olney, Md.; president-elect, W. C. Anderson, executive director, Emily P. Bissell Sanatorium, Wilmington, Del.; president, Victor F. Ludewig, administrator, George Washington University Hospital, Washington; past president, Russell A. Nelson, director, Johns Hopkins Hospital, Baltimore; treasurer, Barry Bowers, director, Hospital for the Women of Maryland, Baltimore; third vice president, Maurice W. J. Abraham, executive director, Kent General Hospital, Dover, Del.; trustee, John A. Schaffer, administrator, Washington County Hospital, Hagerstown, Maryland. Seated (l to r) are: trustee, Sister Mary Thomas Zinkand, R.N., administrator, Mercy Hospital, Baltimore; second vice president, Sister Mary Evangelist, administrator, Georgetown University Hospital, Washington.

number is among children from one to four years of age. Medications in general, and aspirins and barbiturates in particular, are the poisons most frequently taken by children, he said.

Dr. Parrott urged every hospital to promote the concept of poison control, whether it established a center or not. Essential to this concept, he said, is the establishment by hospital pharmacists of a file of information on the composition of both prescriptions and poisonous household articles.

The file should be in a form that can be made available rapidly to a physician calling in an emergency, Dr. Parrott emphasized.

Among the some 250 members of the women's auxiliaries from the Maryland-District of Columbia-Delaware area were Mrs. Alben W. Barkley, widow of the late vice president, and Mrs. Harold H. Burton, wife of the associate justice of the Supreme Court. Justice Burton was co-author of the Hill-Burton hospital construction act when he served in the U.S. Senate.

Dr. Leroy E. Burney, surgeon general of the Public Health Service, greeted the auxiliary members before turning over their meeting to an address by Mrs. Hulda Hubbell, director of volunteer services, United Community Services, Washington.

Mrs. Hubbell said that "more progress has been made in the development of volunteer programs in hospitals than in any other group of institutions or agencies in the health and welfare field." She maintained, however, that "the ideal situation" can only be obtained in a hospital if the director of volunteers and the hospital "share the responsibility for administering the program."

President-elect of the Maryland-District of Columbia-Delaware Hospital Association, is Victor F. Ludewig, administrator, George Washington University Hospital, Washington. He will succeed Dr. Russell A. Nelson, director, Johns Hopkins Hospital, Baltimore.

NEW YORK, PHILADELPHIA BLUE CROSS SEEK RATE INCREASES—Associated Hospital Service of New York and the Associated Hospital Service of Philadelphia, both Blue Cross Plans serving their respective areas, have announced that they will seek 40 per cent rate increases. The requested increase in Philadelphia would range as high as 70 per cent for some groups.

E. A. van Steenwyk, executive vice president of the Philadelphia plan, stated that increases were being sought because of increased hospital costs and greater utilization of hospital facilities by subscribers to the plan.

Hearings on the proposed increases are to be held by Philadelphia and Pennsylvania government officials before the increases may go into effect.

On Nov. 18 in New York City, the state insurance department is to hold a public hearing on the proposed increase there.

UMW DROPS 11 PENNSYLVANIA HOSPITALS FROM PARTICIPATING LIST—Eleven of 28 participating hospitals in Pennsylvania have been dropped from the United Mine Workers Welfare and Retirement Fund rolls as eligible to receive UMW funds for the treatment of UMW Retirement Fund beneficiaries, effective last month.

Of the 17 remaining hospitals 11 are located in Pittsburgh.

The fund also dropped some 200 doctors from its list of physicians who are participating in the care of UMW beneficiaries, leaving some 850 doctors on the participating rolls.

Hospitals and physicians were eliminated from UMW's list following the statement to UMW area medical directors by Dr. Warren F. Draper, executive medical officer of the fund, that "the records and data of the trust fund, based on the past nine years of operation and experience, afford conclusive evidence that quality of service rendered . . . and conservation of resources can be maintained most effectively by limiting payments . . . to physicians and hospitals whose services are most needed."

Hospitals dropped by the UMW are: Allegheny General, St. Francis, and South Side Hospitals, Pittsburgh; Ohio Valley Hospital, McKees Rocks; Canonsburg General Hospital, Canonsburg; Latrobe General Hospital, Latrobe; H. C. Frick Memorial Hospital, Mt. Pleasant; McKeesport Hospital, McKeesport; Citizens General Hospital, New Kensington, and Charleroi-Monessen Hospital, North Charleroi.

In a letter to those physicians eliminated from the fund's rolls, Dr. Leslie A. Falk, UMW fund area medical administrator, stated "the fund will not pay for your professional services, including any initial examination, referral, or care rendered to any of its beneficiaries on or after Oct. 15 . . . except that you will be paid for services necessary to complete the hospital care of any beneficiary patient under your care in a participating hospital on the effective date."

5.1 MILLION PINTS OF BLOOD COLLECTED IN 1956: SURVEY—Some 5.1 million pints of blood were collected in 1956 by U.S. and territorial agencies engaged in blood procurement.

Approximately 4,633,000 transfusions were given to some 2 million patients during that period.

This information was gathered by the Joint Blood Council's Project Advisory Committee by means of a post card survey of 8568 U.S. hospitals and 127 hospitals in U.S. territories and possessions. (Here the word "hospital" means, without qualification, an institution in which patients receive medical or surgical care, the council stated.)

Some 4920 hospitals, or 57.4 per cent, submitted an answer to the survey.

It was found that regional collection centers maintained by the American Red Cross provided 38 per cent of the blood used; hospitals that obtain blood from voluntary, unpaid donors provided 36 per cent; commercial blood banks 11 per cent; nonhospital community blood banks 9.5 per cent; hospitals that furnish blood to other hospitals 4 per cent, and directly paid donors 2 per cent.

Elsewhere in the survey report it was stated that "45 per cent of the hospitals reporting to the committee were in the class 'under 200 transfusions,' yet the same hospitals accounted for only 4 per cent of total usage . . . An effective brake on extravagant claims [regarding blood usage] now emerges from the plain fact that in the United States small blood users predominate numerically."

"Friend . . . or Enema?"

Pardon our light touch . . . but

TRAVAD

does have the "light touch," because it's the only ready-to-use, disposable enema with the aesthetic *plus feature*—18″ of flexible tubing.

Travad, thoroughly hospital tested by 3500 nurses and developed according to their "on-the-job-specifications" offers the following advantages:

- 18″ of flexible tubing for more aesthetic, convenient administration
- pre-lubricated tip in handy side pocket of unit
- nothing to assemble or clean up afterwards
- clear plastic bag to see and regulate solution rate of flow
- can be given in a fraction of the time required for conventional enemas
- time-proved formula . . . each 100 cc. contains 12 Gm. sodium dihydrogen phosphate, 10 Gm. sodium citrate

But, see for yourself ... **at our expense,** *the Advantages of* **Travad**

FLOW VALVE
6-1/2 FLUID OUNCES
TRAVAD
ready-to-use-enema
(disposable unit)
EACH 100 CC CONTAINS SODIUM DIHYDROGEN PHOSPHATE 12 GM.-SODIUM CITRATE 10 GM.
DIRECTIONS: Insert lubricated tip. Push bead to blue line to open flow valve. Squeeze bag gently. Detailed instructions enclosed.
U-112
TRAVENOL LABORATORIES, INC.
Morton Grove, Illinois, U.S.A.

Fill out and mail the card below.

I would like to receive a complimentary trade package of TRAVAD

Name_____ Title_____

Hospital_____

Address_____

City_____ State_____

Comments_____

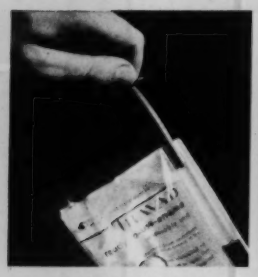
TRAVAD

the most convenient, ready-to-use disposable enema available

Better because

- major savings in personnel time
- releases personnel for other duties
- it's an easier, nicer way to give an enema
- saves storage space
- reduces work load
- costs no more than less convenient units

this is how easy it is to give a TRAVAD enema



pull out pre-lubricated rectal tip . . . then insert it

open valve

squeeze gently

discard unit

TRAVAD . . . *the friendly enema.*

No Postage Stamp Necessary If Mailed in the United States

Postage Will be Paid by Addressee

BUSINESS REPLY CARD
First Class Permit No. 2, Morton Grove, Illinois

TRAVENOL LABORATORIES, INC.
MORTON GROVE, ILLINOIS

TRAVAD
ready-to-use-enema
(disposable unit)
DIRECTIONS: Insert lubricated tip. Push bead to blue line to open flow valve. Squeeze bag gently. Detailed instructions enclosed.
TRAVENOL LABORATORIES, INC.

TRAVENOL LABORATORIES, INC.
Division of Baxter Laboratories, Inc.
MORTON GROVE, ILLINOIS

AMERICAN HOSPITAL ASSOCIATION

DIRECTORY OF OFFICERS, COUNCILS AND COMMITTEES FOR 1958

This directory lists the officers, councils and committees of the Association for the year which began at the close of the Annual Convention in October and which will end at the close of the 1958 Annual Convention.

The pages of this special section have been perforated so that they may be removed from the magazine for convenient reference during the coming year. You may wish to insert this section in your copy of the August 1957 Guide Issue, Part 2, since it completes the AHA directory material in that issue.

Most of the appointments in this listing are for one-year terms. When the appointment is for more than one year, the date of termination is given in parentheses following the individual listing.

OFFICERS

President
Tol Terrell, Shannon West Texas Memorial Hospital, San Angelo, Tex.

President-Elect
Ray Amberg, University of Minnesota Hospitals, Minneapolis 14

Immediate Past President
Albert W. Snoke, M.D., Grace-New Haven Community Hospital, New Haven 4, Conn.

Treasurer
John N. Hatfield, Passavant Memorial Hospital, Chicago 11

Secretary
Edwin L. Crosby, MD., 18 E. Division St., Chicago 10

BOARD OF TRUSTEES

Tol Terrell, *ex officio, chairman*, Shannon West Texas Memorial Hospital, San Angelo, Tex.
A. A. Aita, San Antonio Community Hospital, Upland, Calif. (1958)
Ray Amberg, *ex officio*, University of Minnesota Hospitals, Minneapolis 14
Abbie E. Dunks, Boston Dispensary, Boston 11 (1959)
Rt. Rev. Msgr. Edmund J. Goebel, archdiocesan director of hospitals, Milwaukee 12 (1960)
Edwin L. Harmon, M.D., Grasslands Hospital, Valhalla, N. Y. (1958)
John N. Hatfield, *ex officio*, Passavant Memorial Hospital, Chicago 11
Rear Adm. B. W. Hogan, MC, USN, Bureau of Medicine and Surgery, Department of the Navy, Washington 25 (1960)
Reid T. Holmes, North Carolina Baptist Hospital, Winston-Salem 7, N. C. (1959)
Carl C. Lamley, Stormont-Vail Hospital, Topeka, Kans. (1960)
J. M. McIntyre, Winnipeg Municipal Hospital, Winnipeg, Man. (1958)
Albert W. Snoke, M.D., *ex officio*, Grace-New Haven Community Hospital, New Haven 4, Conn.
Ray K. Swanson, Swedish Hospital, Minneapolis 4 (1959)

COORDINATING COUNCIL

Ray Amberg, *chairman*, University of Minnesota Hospitals, Minneapolis 14
E. Dwight Barnett, M.D., School of Public Health and Administrative Medicine, Columbia University, New York 32
Robin C. Buerki, M.D., Henry Ford Hospital, Detroit 2
Robert T. Evans, Blue Cross Plan for Hospital Care, Chicago 90
Stanley A. Ferguson, University Hospitals of Cleveland, Cleveland 6
Mrs. Chester A. Hoover, (Address: 301 Ocean Ave., Santa Monica, Calif.) Santa Monica Hospital, Santa Monica
Russell A. Nelson, M.D., Johns Hopkins Hospital, Baltimore 5
Boone Powell, Baylor University Hospital, Dallas 10
David B. Wilson, M.D., University Hospital, Jackson 5, Miss.

STANDING COMMITTEE

Committee on Nominations
Ritz E. Heerman, *chairman*, Lutheran Hospital Society of Southern California, 1414 S. Hope St., Los Angeles 15 (1958)
Kenneth B. Babcock, M.D., Joint Commission on Accreditation of Hospitals, 660 N. Rush St., Chicago 11 (1958)
Bolton Boone, Methodist Hospital, Dallas, Tex. (1961)
Frank R. Bradley, M.D., Barnes Hospital, St. Louis 10 (1959)
Ray E. Brown, University of Chicago Clinics, Chicago 37 (1960)
Marshall I. Pickens, Duke Endowment, Charlotte, N.C. (1960)
Lester E. Richwagen, Mary Fletcher Hospital, Burlington, Vt. (1959)

COMMITTEES OF THE BOARD

Committee on Bylaws
(The Council on Association Services serves as the Committee on Bylaws.)

Committee on Distinguished Service Award
(Consists of the active past presidents of the Association under the chairmanship of the immediate past president.)

Committee on Finance
Tol Terrell, *chairman*, Shannon West Texas Memorial Hospital, San Angelo, Tex.
Edwin L. Crosby, M.D., American Hospital Association, 18 E. Division St., Chicago 10
John N. Hatfield, Passavant Memorial Hospital, Chicago 11

Committee on Headquarters Building
John N. Hatfield, *chairman*, Passavant Memorial Hospital, Chicago 11
Ray E. Brown, University of Chicago Clinics, Chicago 37
Robin C. Buerki, M.D., Henry Ford Hospital, Detroit 2
Joseph G. Norby, hospital consultant, 322 E. Michigan St., Milwaukee 2
Secretary: Edwin L. Crosby, M.D., American Hospital Association, 18 E. Division St., Chicago 10

Committee on Listings
Edwin L. Crosby, M.D., *ex officio, chairman*, American Hospital Association, 18 E. Division St., Chicago 10
(The regularly appointed members of this committee, listed below, also serve as representatives to the Joint Commission on Accreditation of Hospitals; their appointments terminate as of December 31 of the years shown.)
Frank R. Bradley, M.D., Barnes Hospital, St. Louis 10 (1960)
Ray E. Brown, University of Chicago Clinics, Chicago 37 (1958)
Stuart K. Hummel, Columbia Hospital, Milwaukee 11 (1959)
Jack Masur, M.D., assistant surgeon general, Public Health Service, Clinical Center, Bethesda 14, Md. (1959)
Rt. Rev. Msgr. Donald A. McGowan, National Catholic Welfare Conference, 1312 Massachusetts Ave., Washington 5 (1960)
John B. Neilson, M.D., Hamilton General Hospitals, Hamilton, Ont. (1959)
Albert W. Snoke, M.D., Grace-New Haven Community Hospital, New Haven 4, Conn. (1958)

Subcommittee on Hospital Architects' Qualifications
David B. Wilson, M.D., *ex officio, chairman*, University Hospital, Jackson 5, Miss.
Richard J. Adams, Sherlock, Smith and Adams, Inc., 303 Washington Ave., Montgomery, Ala. (1959)
Roscoe P. DeWitt, architect, 2025 Cedar Springs Ave., Dallas, Tex. (1960)
Frank S. Groner, Baptist Memorial Hospital, Memphis 3, Tenn. (1959)
John J. Bourke, M.D., Joint Hospital Survey and Planning Commission, 84 Holland Ave., Albany 8, N. Y. (1960)
Reid T. Holmes, North Carolina Baptist Hospital, Winston-Salem 7, N. C. (1958)
Wesley G. Lamer, Physicians and Surgeons Hospital, Portland, 9, Ore. (1959)
Frank Latenser, John Latenser and Sons, 1307 Farnam St., Omaha 2, Nebr. (1958)
Chester C. Woods, architect, 2842 Bloor St. W., Toronto, Ont. (1959)

Committee on Membership
(The Council on Association Services serves as the Committee on Membership)

Committee on Project Review
Tol Terrell, *ex officio, chairman*, Shannon West Texas Memorial Hospital, San Angelo, Tex.
Ray Amberg, *ex officio*, University of Minnesota Hospitals, Minneapolis 14
Edwin L. Crosby, M.D., *ex officio*, American Hospital Association, Chicago 10
John N. Hatfield, *ex officio*, Passavant Memorial Hospital, Chicago 11.
Philip M. Hauser, Ph.D., University of Chicago, Chicago 37 (1959)
Jack Masur, M.D. assistant surgeon general, Public Health Service, Clinical Center, Bethesda 14, Md. (1961)
Albert W. Snoke, M.D., *ex officio*, Grace-New Haven Community Hospital, New Haven 4, Conn.
Secretary: Alan E. Treloar, Ph.D., American Hospital Association, 18 E. Division St., Chicago 10

Committee on Resolutions
(The Board of Trustees acts as a referral committee to which resolutions shall be submitted prior to being placed before the House of Delegates.)

Representatives to Joint Committees and Joint Commissions with Other Organizations

Inter-Association Committee on Health, representing American Dental Association, American Hospital Association, American Medical Association, American Nurses' Association, American Public Health Association and American Public Welfare Association.
Ray Amberg, *ex officio*, University of Minnesota Hospitals, Minneapolis 14
Edwin L. Crosby, M.D., *ex officio*, American Hospital Association, Chicago 10
Tol Terrell, *ex officio*, Shannon West Texas Memorial Hospital, San Angelo, Tex.

Joint Advisory Committee of Nine, representing American Hospital Association, American Protestant Hospital Association and Catholic Hospital Association.
Ray Amberg, *ex officio*, University of Minnesota Hospitals, Minneapolis 14
Robin C. Buerki, M.D., *ex officio*, Henry Ford Hospital, Detroit 2
Tol Terrell, *ex officio*, Shannon West Texas Memorial Hospital, San Angelo, Tex.

Joint Commission on Accreditation of Hospitals
(See Committee on Listings.)

Joint Committee with American College of Hospital Administrators
Frank R. Bradley, M.D., chairman of AHA group, Barnes Hospital, St. Louis 10 (1959)
Ray E. Brown, University of Chicago Clinics, Chicago 37 (1958)
Joseph G. Norby, hospital consultant, 322 E. Michigan St., Milwaukee 2 (1958)
Leo G. Schmelzer, Wilmington General Hospital, Wilmington 5, Del. (1959)
Tol Terrell, *ex officio*, Shannon West Texas Memorial Hospital, San Angelo, Tex.

Liaison Committee with American Medical Association
Tol Terrell, chairman of AHA group, Shannon West Texas Memorial Hospital, San Angelo
Ray Amberg, University of Minnesota Hospitals, Minneapolis 14
Robin C. Buerki, M.D., Henry Ford Hospital, Detroit 2
Russell A. Nelson, M.D., Johns Hopkins Hospital, Baltimore 5
Albert W. Snoke, M.D., Grace-New Haven Community Hospital, New Haven 4, Conn.

Joint Committee on Medical Professional Liability with American Medical Association
Ray E. Brown, University of Chicago Clinics, Chicago 37
August H. Groeschel, M.D., The New York Hospital, New York 21
James E. Ludlam (Address: 621 Hope St., Los Angeles) California Hospital Association, San Francisco

COUNCIL ON ADMINISTRATIVE PRACTICE

Stanley A. Ferguson, *chairman*, University Hospitals of Cleveland, Cleveland 6
J. Milo Anderson, *vice chairman*, Strong Memorial Hospital, Rochester 20, N. Y. (1958)
Sister Mary Brigh, R.N., St. Mary's Hospital, Rochester, Minn. (1959)
Horace M. Cardwell, Memorial Hospital, Lufkin, Tex. (1960)
James M. Crews, Methodist Hospital, Memphis 4, Tenn. (1958)
George A. Hay, Hospital of the Woman's Medical College of Pennsylvania, Philadelphia 29 (1960)
Riley McDavid, Kenosha Hospital, Kenosha, Wis. (1959)
Clyde L. Sibley, Birmingham Baptist Hospital, Birmingham 11, Ala. (1960)
Richard T. Viguers, New England Center Hospital, Boston 11 (1959)
Linus A. Zink, M.D., Veterans Administration, Washington 25 (1958)
Secretary: Richard L. Johnson, American Hospital Association, 18 E. Division St., Chicago 10

Committee on Accounting and Business Practices
Paul D. Shannon, *chairman*, Royal Victoria Hospital, Montreal 2, Que.
Sister Elise, Sisters of Charity, Mount St. Joseph, Ohio
Frank H. Evans, Hospital Service Corporation of Western New York, 298 Main St., Buffalo 2, N.Y.
C. Henry Hottum Jr., Methodist Hospital, Memphis 4, Tenn.
R. N. Kerst, Presbyterian Hospital in the City of New York, New York 32
Henry Lahaug, Trinity Hospital, Minot, N. Dak.
Jack F. Monahan Jr., Florida Hospital Association, P.O. Box 6455, Orlando, Fla.
Technical Consultant: Charles G. Roswell, United Hospital Fund, 3 E. 54th St., New York 22

Subcommittee for Budgeting Manual
Paul D. Shannon, *chairman*, Royal Victoria Hospital, Montreal 2, Que.
E. N. Cappleman, Dallas County Hospital District, Dallas 19, Tex.
Louis S. Graham, Western Pennsylvania Hospital, Pittsburgh 24
Robert E. Linde, University of Texas, Austin, Tex.
Robert A. Molgren, St. Luke's Hospital, Kansas City 11, Mo.

Committee on Engineering and Maintenance
C. R. Youngquist, *chairman*, Shadyside Hospital, Pittsburgh 32
Arthur D. Barnes, Memorial Center for Cancer and Allied Diseases, New York 21
C. Franklin Fielden Jr., Memorial Hospital, Colorado Springs, Colo.
John A. Holbrook, Presbyterian Hospital, Chicago 12
Everett W. Jones, 625 Mantazes Ct., Ft. Myers Beach, Fla.
Daniel M. Roop, Baptist Memorial Hospital, Memphis 3, Tenn.
Charles V. Wynne, Waterbury Hospital, Waterbury 8, Conn.

Committee on Hospital Organization
Col. George E. Schunior, MC, *chairman*, US Army Hospital, Camp Carson, Colo.
Robert W. Bachmeyer, St. Barnabas Hospital, Minneapolis 4
Leonard O. Bradley, M.D., Winnipeg General Hospital, Winnipeg 3, Man.
William S. Brines, Newton-Wellesley Hospital, Newton Lower Falls 62, Mass.
Everett A. Johnson, Methodist Hospital, Gary, Ind.
R. Z. Thomas Jr., Charlotte Memorial Hospital, Charlotte 3, N. C.
Richard Wittrup, University Hospital, University of Kentucky Medical Center, Lexington, Ky.

Committee on Housekeeping in Hospitals
Harvey Schoenfeld, *chairman*, Nathan and Miriam Barnert Memorial Hospital, Paterson, N. J.
Ellen Cowan, Toronto Western Hospital, Toronto 28, Ont.
Sister Ingeborg Blomberg, Immanuel Hospital, Omaha 11, Nebr.
Leland J. Mamer, St. Luke's Hospital, New York 25
S. Earl Thompson, Ph.D., Michigan State University, East Lansing, Mich.
Special Committee Assistant: Mrs. Mary R. Waller, 118 4th St., Little Valley, N. Y.

Committee on Insurance for Hospitals
William K. Klein, *chairman*, Long Island College Hospital, Brooklyn 1, N. Y.
H. Robert Cathcart, Pennsylvania Hospital, Philadelphia 7
Carl C. Drewry, Raleigh General Hospital, Beckley, W. Va.
Herbert M. Krauss, Latrobe Hospital, Latrobe, Pa.
James E. Ludlam (Address: 621 Hope St., Los Angeles), California Hospital Association, San Francisco
Ernest C. Shortliffe, M.D., Hartford Hospital, Hartford 15, Conn.
Special Consultant: William T. Robinson, Hospital Association of New York State, 11 N. Pearl St., Albany 7, N. Y.

Committee on Laundry Management
Wade Mountz, *chairman*, Norton Memorial Infirmary, Louisville 3, Ky.
Edwin T. Cullen, Salem Hospital, Salem, Mass.
Robert Dobson, New York City Department of Hospitals, New York 13
M. Bill Newman, Community Hospital, Indianapolis 19
Donalda Smith, University Hospitals of Cleveland, Cleveland 6
Warren Soderberg, Fairview Hospital, Minneapolis 6
Ray P. Woodham, Presbyterian Hospital Center, Albuquerque, N. Mex.
Special Consultant: Joseph F. Krawiec, Pennsylvania State University, University Park, Pa.

Committee on Methods Improvement
Matthew F. McNulty Jr., *chairman*, University Hospital and Hillman Clinics, Birmingham 3, Ala.
Rebecca Jack, R.N., Blodgett Memorial Hospital, Grand Rapids 6, Mich.
Lawrence R. Payne, Baptist Memorial Hospital, Jacksonville 7, Fla.
Hal G. Perrin, Bishop Clarkson Memorial Hospital, Omaha 5, Nebr.
Clifford F. Schwarberg Jr., Presbyterian Inter-Community Hospital, Whittier, Calif.
Kenneth J. Shoos, St. Luke's Hospital, Cleveland 4
Harold E. Smalley, University of Pittsburgh, Pittsburgh 13

Committee on Personnel Administration
George W. Graham, M.D., *chairman*, Ellis Hospital, Schenectady 8, N. Y.
George J. Bartel, Monmouth Memorial Hospital, Long Branch, N. J.
Willard P. Earngey Jr., Harris Hospital, Fort Worth 4, Tex.
William J. Gnadt, Bonne Terre Hospital, Bonne Terre, Mo.
Sidney Lewine, Mount Sinai Hospital, Cleveland 6
Louis Liswood, National Jewish Hospital at Denver, Denver 6
Irene E. Oliver, R.N., Magic Valley Memorial Hospital, Twin Falls, Idaho

Committee on Purchasing, Simplification and Standardization
Mark Berke, *chairman*, Mt. Zion Hospital, San Francisco 15
Leonard P. Goudy, *vice chairman*, Proctor Community Hospital, Peoria 6, Ill.

Subcommittee on Purchasing
Mark Berke, *chairman*, Mt. Zion Hospital, San Francisco 15
Herbert A. Anderson, Lincoln General Hospital, Lincoln 2, Nebr.
Norman R. Brown, Concord Hospital, Concord, N. H.
J. J. Ritterskamp Jr., Washington University, St. Louis 10
George H. Stone, John D. Archbold Memorial Hospital, Thomasville, Ga.
Paul E. Widman, Cleveland Clinic Hospital, Cleveland 6
John Williams, Harris Hospital, Fort Worth 4, Tex.

Subcommittee on Simplification and Standardization
Leonard P. Goudy, *chairman*, Proctor Community Hospital, Peoria 6, Ill.
Charles E. Burbridge, Freedmen's Hospital, Washington 25
Reuben H. Graham, North Carolina Baptist Hospital, Winston-Salem 7, N. C.
Gene Kidd, Baptist Hospital, Nashville 4, Tenn.

Committee on Safety
Harriet L. Aberg, *chairman*, Galesburg Cottage Hospital, Galesburg, Ill.
Edward Gray Halstead, architect, 228 N. LaSalle St., Chicago 1
William K. Klein, Long Island College Hospital, Brooklyn, N. Y.
Dorothy Pellenz, Crouse-Irving Hospital, Syracuse 10, N. Y.
Sister M. Theophane, R.N., St. Joseph's Hospital, Lorain, Ohio
George J. Thomas, M.D., St. Francis General Hospital and Rehabilitation Institute, Pittsburgh 1
P. V. Tilden, Veterans Administration, Washington 25
Helen Willems, National Safety Council, 425 N. Michigan Ave., Chicago 11.

Departmental Committee of the Personal Membership Department for Hospital Engineers
Arthur D. Barnes, *chairman*, Memorial Center for Cancer and Allied Diseases, New York 21 (1958)
Roy Hudenburg, *vice chairman*, Community Health Association, 8143 E. Jefferson Ave., Detroit 14
Harvey J. Caddell, William Beaumont Hospital, Royal Oak, Mich. (1958)
James M. Crews, Methodist Hospital, Memphis 4, Tenn. (1960)
Joseph W. Degen, Massachusetts General Hospital, Boston 14 (1959)
Leland J. Mamer, St. Luke's Hospital, New York 25 (1958)
Daniel M. Roop, Baptist Memorial Hospital, Memphis 3, Tenn. (1958)
C. R. Youngquist, Shadyside Hospital, Pittsburgh 32, Pa. (1958)

Nominating Committee of the Personal Membership Department for Hospital Engineers
Edward H. Thompson, *chairman*, North Carolina Memorial Hospital, Chapel Hill, N. C.
Francis R. Benvenete, St. Michael's Hospital, Toronto 12, Ont. (1960)
Glover H. Boone, Passavant Memorial Hospital, Chicago 11 (1961)
William H. Leslie, Phoenixville Hospital, Phoenixville, Pa. (1959)

Representatives to Joint Committees and to Committees of Other Organizations

Joint Committee with American Association of Hospital Accountants
Paul D. Shannon, Royal Victoria Hospital, Montreal 2, Que.
Charles G. Roswell, United Hospital Fund, 3 E. 54th St., New York 22

Committee on Associations and Small Businesses of National Safety Council
Harriet L. Aberg, Galesburg Cottage Hospital, Galesburg, Ill.

Committee on Industrial Conference of National Safety Council
Harriet L. Aberg, Galesburg Cottage Hospital, Galesburg, Ill.

Committee on Life Safety of National Fire Protection Association
Edward Gray Halstead, architect, 228 N. LaSalle St., Chicago 1

Representatives to Committees of United States Department of Commerce and American Standards Association
Wallace O. Banker, The Roosevelt Hospital, New York 19
CS146-47 Gowns for Hospital Patients
Waldo W. Bass, Milwaukee Sanitarium, Wauwatosa, Wis.
R224 Medical and Surgical Hypodermic Needles (For Hospital Use)
R239 Surgical Sutures
R240 Clinical Utensils, Aluminum, Enameled Steel and Stainless Steel
Z70 Conference on Hypodermic Syringes and Needles
Franklin D. Carr, Detroit Memorial Hospital, Detroit 26
R249 Plastic Tableware
Roger W. DeBusk, M.D., Grace Hospital, Detroit 1
CS37-31 Steel Bone Plates and Screws
ISO/TC 76 Transfusion Equipment for Medical Use
Joint Committee for the Study of Surgical Materials
Robert Dobson, City of New York, Department of Hospitals, New York 13 Z8 Sectional Committee, Safety Code for Laundries and Dry Cleaning
Elizabeth C. Downes, The Mountainside Hospital, Montclair, N. J.
Subcommittee 1-Hand and Dishwashing Compounds

Anthony W. Eckert, Perth Amboy General Hospital, Perth Amboy, N. J.
ISO/TC 75 Conference on Stretchers and Stretcher Carriers
Eva H. Erickson, R.N., Children's Orthopedic Hospital, Seattle 5
Section Committee Z79 on Standardization of Anesthetic Equipment
Edgar L. Geibel, Stamford Hospital, Stamford, Conn.
Section Committee Z79 on Standardization of Anesthetic Equipment
Roald B. Glesne, Methodist Hospital, Gary, Ind.
R106 Hospital Plumbing Fixtures
CS20-49 Vitreous China Plumbing Fixtures
Leonard P. Goudy, Proctor Community Hospital, Peoria 6, Ill.
R85 Adhesive Plaster
R86 Surgical Gauze
R133 Surgical Dressings
CS1-52 Clinical Thermometers
American Standards Association Sectional Committee and Subcommittee, Consumer Goods Standards Board
Reuben H. Graham, North Carolina Baptist Hospital, Winston-Salem 7, N. C.
R-24 Hospital Beds
CS54-36 Mattresses for Hospitals
CS55-36 Mattresses for Institutions
CS182-51 Latex Foam Mattresses for Hospitals
Edward Gray Halstead, architect, 228 N. LaSalle St., Chicago 1
A9 Building Exit Codes
A 22 Safety Code for Walkway Surfaces
Ruth Kahn, American Hospital Association, Chicago 10
Z64 Mass Feeding Kitchen Utensils and Containers
Col. Bernard J. Kotte, MSC, Brooke Army Medical Center, Fort Sam Houston, Tex.
R176 Color Marking for Anesthetic Gas Cylinders
Raymond H. Layer, Hospital Bureau of Standards and Supplies, 247 Park Ave., New York 17
R74 Hospital and Institutional Cotton Textiles
L 4 Specifications and Standards for Sheets and Sheeting
L22 Rayon Finished Fabrics
K63 Subcommittee II Metal Polishing Products
ISO/TC84 Syringes and Needles
Leland J. Mamer, St. Luke's Hospital, New York
K63 Minimum Performance Standards for Institutional Cleaning and Maintenance Supplies
Subcommittee III Surface Cleaning Products
Subcommittee IV Floor and Furniture Polishing Products
Cornelia C. Pratt, Orange Memorial Hospital, Orange, N. J.
L12 Bedding and Upholstery
Sol Singerman, Michael Reese Hospital, Chicago 16, Ill.
CS136-46 Blankets for Hospitals
Bernhard Steinberg, M.D., Toledo Hospital, Toledo, Ohio
ISO/TC 48 Laboratory Glassware and Related Apparatus
Peter B. Terenzio, Roosevelt Hospital, New York 19
Z66 Prevention or Control of Hazards to Children
Paul E. Widman, Cleveland Clinic Hospital, Cleveland 6, Ohio
R 40 Hospital Chinaware
CS38-32 Hospital Rubber Sheeting
CS40-32 Surgeons Rubber Gloves
CS41-32 Surgeons Latex Gloves
CS114-43 Hospital Sheeting for Mattress Protection

COUNCIL ON ASSOCIATION SERVICES

Boone Powell, *chairman*, Baylor University Hospital, Dallas 10
Pat N. Groner, *vice chairman*, Baptist Hospital, Pensacola, Fla. (1959)
John A. Dare, Virginia Mason Hospital, Seattle 1 (1959)
Albert G. Hahn, Protestant Deaconess Hospital, Evansville 10, Ind. (1958)
Leo M. Lyons, American Protestant Hospital Association, 105 W. Adams St., Chicago 3 (1960)
Roy R. Prangley, St. Luke's Hospital, Denver 3 (1960)
Homer A. Reid, Lovelace Clinic, Albuquerque, N. Mex. (1958)
Donald M. Rosenberger, Maine Medical Center, Portland 4, Maine (1959)
Charles M. Royle, Hospital Association of New York State, 11 N. Pearl St., Albany 7, N. Y. (1958)
Abram L. Van Horn, M.D., Kate Macy Ladd Convalescent Home, Far Hills, N. J. (1960)
Secretary: Edmond J. Lanigan, American Hospital Association, 18 E. Division St., Chicago 10

Committee on Metropolitan Hospital Associations

Jacques Cousin, *chairman*, Greater Detroit Area Hospital Council, 1082 Penobscot Bldg., Detroit 26
Wendell H. Carlson, Chicago Hospital Council, 105 W. Adams St., Chicago 3
John V. Connorton, Ph.D., Greater New York Hospital Association, 3 E. 54th St., New York 22
J. Harold Johnston, *ex officio*, Middle Atlantic Hospital Assembly, 46 S. Clinton Ave., Trenton 9, N. J.
Stuart W. Knox, *ex officio*, Connecticut Hospital Association, 160 St. Ronan St., New Haven 11, Conn.

Committee on Regional Hospital Associations

J. Harold Johnston, *chairman*, Middle Atlantic Hospital Assembly, 46 S. Clinton Ave., Trenton 9, N. J.
Charles W. Flynn, Southeastern Hospital Conference, Box 1043, Jackson, Miss.
Glen Taylor, Upper Midwest Hospital Conference, University of Minnesota, Minneapolis 14
Jacques Cousin, *ex officio*, Greater Detroit Area Hospital Council, 1082 Penobscot Bldg., Detroit 26
Stuart W. Knox, *ex officio*, Connecticut Hospital Association, 160 St. Ronan St., New Haven 11, Conn.

Committee on State Hospital Associations

Stuart W. Knox, *chairman*, Connecticut Hospital Association, 160 St. Ronan St., New Haven 11, Conn.
Avery M. Millard, California Hospital Association, 760 Market St., San Francisco 2
Cleveland Rodgers, Oklahoma Hospital Association, 1215 S. Boulder, Tulsa, Okla.
Jacques Cousin, *ex officio*, Greater Detroit Area Hospital Council, 1082 Penobscot Bldg., Detroit 26
J. Harold Johnston, *ex officio*, Middle Atlantic Hospital Assembly, 46 S. Clinton Ave., Trenton 9, N. J.

Committee to Develop Administrative Regulations for Council and Committee Actions

Hubert W. Hughes, *chairman*, 945 Niagara St., Denver 7
S. A. Ruskjer, Waverly Hills Tuberculosis Sanatorium, Waverly Hills, Ky.
W. W. Stadel, M.D., San Diego County General Hospital, San Diego 3, Calif.

BLUE CROSS COMMISSION

Robert T. Evans, *chairman*, Blue Cross Plan for Hospital Care, Chicago 90 (1958)
Charles Garside, *vice chairman*, Associated Hospital Service of New York, New York 16 (1959)
H. Charles Abbott, Hospital Service of Southern California, Los Angeles 27 (1959)
Kenneth B. Babcock, M.D., Joint Commission on Accreditation of Hospitals, 660 N. Rush St., Chicago 10 (1959)
Rt. Rev. Msgr. John W. Barrett, archdiocesan director of hospitals, Chicago 5 (1958)
Joseph O. Burger, Nebraska Blue Cross Hospital Service Association, Omaha 2, Nebr. (1958)
J. Campbell Butler, Group Hospital Service, Inc., Syracuse 2, N. Y. (1958)
Frank S. Groner, Baptist Memorial Hospital, Memphis 3, Tenn. (1960)
Elisha M. Herndon, Hospital Care Association, Inc., Durham, N. C. (1959)
John R. Hill, Tennessee Hospital Service Association, Chattanooga 2, Tenn. (1958)
Walter R. McBee, Group Hospital Service, Inc., Dallas 22, Tex. (1958)
E. Duncan Millican, Quebec Hospital Service Association, Montreal 2, Que. (1958)
John B. Morgan Jr., Associated Hospital Service, Inc., Youngstown 7, Ohio (1959)
Stanley H. Saunders, Hospital Service Corp. of Rhode Island, Providence 2, R. I. (1959)
E. A. van Steenwyk, Associated Hospital Service of Philadelphia, Philadelphia 2 (1958)
Director: Richard M. Jones, 425 N. Michigan Ave., Chicago 11

COUNCIL ON GOVERNMENT RELATIONS

Robin C. Buerki, M.D., *chairman*, Henry Ford Hospital, Detroit 2
William L. Wilson, *vice chairman*, Mary Hitchcock Memorial Hospital, Hanover, N. H. (1959)
Ted Bowen, Methodist Hospital, Houston 25, Tex. (1958)
Ritz E. Heerman, Lutheran Hospital Society of Southern California, 1414 S. Hope St., Los Angeles 15 (1958)
Harry E. Panhorst, Barnes Hospital, St. Louis 10 (1960)
Edwin B. Peel, Georgia Baptist Hospital, Atlanta 3 (1959)
Harold Prather, Richmond Memorial Hospital, Richmond 27, Va. (1960)
Martin R. Steinberg, M.D., Mount Sinai Hospital, New York 29 (1959)
Rt. Rev. Msgr. Charles A. Towell, diocesan director of hospitals, P. O. Box 681, Covington, Ky. (1958)
Kenneth Wallace, St. John's Hospital, Tulsa, Okla. (1960)
Secretary: Kenneth Williamson, Washington Service Bureau, Mills Building, 17th St. and Pennsylvania Ave., N.W., Washington 6

Committee on International Relations

Robin C. Buerki, M.D., *chairman*, Henry Ford Hospital, Detroit 2
George E. Armstrong, M.D., New York University-Bellevue Medical Center, New York 3
Vane M. Hoge, M.D., assistant surgeon general, Public Health Service, Division of Hospital and Medical Services, Washington 25
Stuart K. Hummel, Columbia Hospital, Milwaukee 11
Fred A. McNamara, Bureau of the Budget, Executive Office of the President, Washington 25
Albert W. Snoke, M.D., Grace-New Haven Community Hospital, New Haven 4, Conn.

Advisory Committee on Latin-American Project

Consists of the members of the Committee on International Relations and the following:
Kenneth B. Babcock, M.D., Joint Commission on Accreditation of Hospitals, 660 N. Rush St., Chicago 11
Dean Conley, American College of Hospital Administrators, 620 N. Michigan Ave., Chicago 11
Rt. Rev. Msgr. Donald A. McGowan, National Catholic Welfare Conference, 1312 Massachusetts Ave., Washington 5
Myron E. Wegman, M.D., Pan American Sanitary Bureau, Washington 25

Committee on Legislation for Fund Raising

R. O. D. Hopkins, United Hospital Fund, 3 E. 54th St., New York 22
Rt. Rev. Msgr. George Lewis Smith, diocesan director of hospitals, Diocese of Charleston, Aiken, S. C.
Martin R. Steinberg, M.D., Mount Sinai Hospital, New York 29

Committee on State Programs for Indigent Care

Edwin B. Peel, *chairman*, Georgia Baptist Hospital, Atlanta 3
John Bigelow, Washington State Hospital Association, 370 Skinner Bldg., Seattle 1
Henry D. Brickman, Massachusetts Hospital Association, 14 Somerset St., Boston 8
Henry H. Miller, Tennessee Hospital Association, P.O. Box 767, Nashville 2, Tenn.

Committee on Use of Radio Communications by Hospitals

George W. Graham, M.D., *chairman*, Ellis Hospital, Schenectady 8, N. Y.
Bernard L. Felton, Connecticut Hospital Association, 160 St. Roman St., New Haven 11, Conn.
Fred Foster, Massachusetts General Hospital, Boston 14
Royal Weller, Ph.D., Stromberg-Carlson Company, Rochester 3, N. Y.

Committee on Veterans Relations

Martin R. Steinberg, M.D., *chairman*, Mount Sinai Hospital, New York 29
Lester E. Richwagen, Mary Fletcher Hospital, Burlington, Vt.
L. H. Gunter, Veterans Administration Hospital, Hines, Ill.
Matthew F. McNulty Jr., University Hospital and Hillman Clinics, Birmingham 3, Ala.
Victor F. Ludewig, George Washington University Hospital, Washington 7, D. C.

Committee to Discuss Medicare Program

Robin C. Buerki, M.D., *chairman*, Henry Ford Hospital, Detroit 2
Ritz E. Heerman, Lutheran Hospital Society of Southern California, 1414 S. Hope St., Los Angeles 15
Russell A. Nelson, M.D., Johns Hopkins Hospital, Baltimore 5

Committee to Study Health Needs of the Aged

James P. Dixon, M.D., *chairman*, Department of Public Health, Philadelphia 7
Ray E. Brown, University of Chicago Clinics, Chicago 37
Philip D. Bonnet, M.D., Massachusetts Memorial Hospitals, Boston 18
J. Douglas Colman, Blue Cross Association, 55 E. 34th St., New York 16

COUNCIL ON HOSPITAL AUXILIARIES

Mrs. Chester A. Hoover, *chairman*, (Address: 301 Ocean Ave., Santa Monica, Calif.), Women's Auxiliary of the Santa Monica Hospital
Mrs. Palmer Gaillard Jr., *vice chairman*, (Address: 301 E. Delwood Dr., Mobile 6, Ala.), Women's Auxiliary, Mobile Infirmary (1958)
Mrs. Ernest R. Anthis, (Address: Cherry Knoll, Rte. 1, Muskogee, Okla.), Board of Women's Hospital Auxiliary, Muskogee General Hospital (1958)
Mrs. Columbus Conboy (Address: 1885 Rutherford Ave., Louisville 17, Ky.), Ladies Auxiliary of St. Joseph Infirmary (1959)
Mrs. Sinton P. Hall (Address: 2640 Briarcliffe Ave., Cincinnati 13), The Co-operative Society, Children's Hospital (1959)
Guy M. Hanner, Good Samaritan Hospital, Phoenix, Ariz. (1960)
Mrs. Harry Milton, (Address: RR 3, Box 455, Creve Coeur, Mo.), Jewish Hospital of St. Louis Auxiliary, St. Louis 10 (1960)
F. Ross Porter, Duke Hospital, Durham, N. C. (1959)

Mrs. H. Shelton Smith (Address: 2721 Dogwood Rd., Durham, N. C.), Duke Hospital Woman's Auxiliary (1958)
Laura Vossler, Presbyterian Hospital in the City of New York, New York 32 (1958)
Secretary: Patricia Sussmann, American Hospital Association, 18 E. Division St., Chicago 10

Committee on Hospital Careers

Mrs. Sinton P. Hall, *chairman*, (Address: 2640 Briarcliffe Ave., Cincinnati 13), The Cooperative Society, Children's Hospital
Dina O. Bremness, Glenwood Community Hospital, Glenwood, Minn.
Edward H. Heyd, Rowan Memorial Hospital, Salisbury, N. C.
Alfred Marshall, Grace-New Haven Community Hospital, New Haven 4, Conn.
Melba Powell (Address: 536 School St., Clarksdale, Miss.), Coahoma County Woman's Auxiliary
John M. Stacey, University of Virginia Hospital, Charlottesville, Va.

Committee to Develop Program for Directors of Hospital Volunteers

Mrs. Palmer Gaillard Jr., *chairman* (Address: 301 E. Delwood Dr., Mobile 16, Ala.), Woman's Auxiliary, Mobile Infirmary.
Olga Benderoff, City Hospital, Cleveland 9
John M. Danielson, Evanston Hospital, Evanston, Ill.
Max L. Hunt, Yakima Valley Memorial Hospital, Yakima, Wash.
Mrs. Vivien Ginsburg Raskin, Michael Reese Hospital, Chicago 16
Mrs. Kurt A. Scharbau (Address: 2329 Clinton Pl., Rockford, Ill.), Women's Auxiliary, Rockford Memorial Hospital Auxiliary

Steering Committee of American Psychiatric Association for the Study of Volunteer Services in Psychiatric Hospitals

Mrs. George C. Capen (Address: 87 Walbridge Rd., West Hartford 7, Conn.), Women's Auxiliary, Hartford Hospital
Mrs. Viola Pinanski, (Address: 283 Buckminster Rd., Brookline 46, Mass.), Beth Israel Hospital, Boston 15

COUNCIL ON PLANNING, FINANCING AND PREPAYMENT

David B. Wilson, M.D., *chairman*, University Hospital, Jackson 5, Miss.
James M. Daniel, *vice chairman*, Columbia Hospital of Richland County, Columbia 4, S. C. (1958)
Alfred Paul Bay, M.D., Topeka State Hospital, Topeka, Kans. (1959)
Jay W. Collins, Euclid-Glenville Hospital, Euclid 19, Ohio (1958)
Comdr. L. J. Elsasser, USN, Hospital Administration Division, Department of the Navy, Bureau of Medicine and Surgery, Washington 25 (1958)
Herman L. Herold, North Louisiana Sanitarium, Shreveport 7, La. (1960)
Wesley G. Lamer, Physicians and Surgeons Hospital, Portland 9, Ore. (1959)
Sidney Liswood, New Mount Sinai Hospital, Toronto 2, Ont. (1959)
Delbert L. Pugh, Columbus Hospital Federation, 1666 Broad St., Columbus 3, Ohio (1960)
Sister Mary Vincent, R.N., St. Joseph's Hospital, Fort Worth 4, Tex. (1960)
Secretary: Hiram Sibley, American Hospital Association, 18 E. Division St., Chicago 10

Committee on Disaster Planning

Dean A. Clark, M.D., *chairman*, Massachusetts General Hospital, Boston 14
B. I. Burns, M.D., commissioner of hospitals, Kansas City 8, Mo.
Brig. Gen. Harold H. Twitchell, USAF (MC), Continental Air Command, Mitchell Air Force Base, Hempstead, N. Y.
Joseph W. Hinsley, Lake Charles Memorial Hospital, Lake Charles, La.
Fred W. Moore, Rideout Hospital, Marysville, Calif.
Mrs. Albert C. Rood, (Address: 3104 Burton Ave., S.E.), Presbyterian Hospital Center Woman's Auxiliary, Albuquerque, N. Mex.
Sister Mary Reginald, Mercy Community Hospital, Manistee, Mich.
Consultants:
Harold C. Lueth, M.D., 636 Church Street, Evanston, Ill.
Fred A. McNamara, Bureau of the Budget, Executive Office of the President, Washington 25

Committee on Financing Hospital Capital Requirements

Edward K. Warren, *chairman*, Field Point Circle, Greenwich, Conn.
James Kittleman, Presbyterian-St. Luke's Hospital, Chicago 12
Allen Merrell, Greater Detroit Area Hospital Council, 1082 Penobscot Bldg., Detroit 26
John H. Zenger, Utah Valley Hospital, Provo, Utah

Committee on Hospital Planning

Delbert L. Pugh, *chairman*, Columbus Hospital Federation, 1666 Broad St., Columbus 3, Ohio
John W. Cronin, M.D., assistant surgeon general, Public Health Service, Bureau of Medical Services, Washington 25
C. C. Hillman, M.D., 223 S. E. First Street, Miami 32, Fla.
Duane E. Johnson, University of Nebraska Hospital, Omaha 5, Nebr.
Aaron E. Kiff, York & Sawyer, 101 Park Avenue, New York 17
Helen Knudsen, M.D., State Department of Health, Minneapolis 14
Jacque B. Norman, hospital consultant, 8 S. Church Street, Greenville, S. C.
C. Rufus Rorem, Ph.D., Hospital Council of Philadelphia, 311 S. Juniper St., Philadelphia 7
J. Milo Anderson, Strong Memorial Hospital, Rochester 20, N. Y. (Representing Council on Administrative Practice)
William L. Wilson, Mary Hitchcock Memorial Hospital, Hanover, N. H. (Representing Council on Government Relations)
Lloyd H. Gaston, M.D., St. Luke's Hospital, New York 25 (Representing Council on Professional Practice)

Committee on Prepayment, Reimbursement and Blue Cross

James M. Daniel, *chairman*, Columbia Hospital of Richland County, Columbia, S. C.
Richard O. Cannon, M.D., Vanderbilt University Hospital, Nashville 5, Tenn.
William J. Donnelly, Greenwich Hospital, Greenwich, Conn.
Richard Highsmith, Samuel Merritt Hospital, Oakland 9, Calif.
Henry J. Meiners, Cushing Memorial Hospital, Leavenworth, Kans.
Robert M. Sigmond, Hospital Council of Western Pennsylvania, 1047 Union Trust Bldg., Pittsburgh 19

Committee on Reimbursement for Outpatient Care

Daniel E. Gay, *chairman*, Memorial Hospital of Chatham County, Savannah, Ga.
Richard J. Hines, University Hospital, Ann Arbor, Mich.
Harold T. Prentzel, Montgomery Hospital, Norristown, Pa.
Charles G. Roswell, United Hospital Fund, 3 E. 54th St., New York 22
Albert H. Scheidt, Dallas County Hospital District, Dallas 19

Committee to Write a Manual on Development of Architectural Programs

William L. Wilson, *chairman*, Mary Hitchcock Memorial Hospital, Hanover, N. H.
Robert W. Cutler, Skidmore, Owings & Merrill, 575 Madison Ave., New York 22
Aaron N. Kiff, York & Sawyer, 101 Park Ave., New York 17
Jacque B. Norman, hospital consultant, 8 S. Church St., Greenville, S. C.
E. Todd Wheeler, architect, 265 Wood Court, Wilmette, Ill.

Representatives to Other Committees

Medical Advisory Committee on Civil Defense, Federal Civil Defense Administration
Sister Mary Reginald, Mercy Community Hospital, Manistee, Mich.
Joint Committee with Association of Hospital Planning Agencies
C. Rufus Rorem, Hospital Council of Philadelphia, 311 S. Juniper St., Philadelphia 7

COUNCIL ON PROFESSIONAL PRACTICE

Russell A. Nelson, M.D., *chairman*, Johns Hopkins Hospital, Baltimore 5
T. Stewart Hamilton, M.D., *vice chairman*, Hartford Hospital, Hartford 15, Conn. (1960)
Louis B. Blair, St. Luke's Methodist Hospital, Cedar Rapids, Iowa (1960)
Lawrence J. Bradley, Genesee Hospital, Rochester 7, N. Y. (1958)
George E. Cartmill Jr., Harper Hospital, Detroit 1 (1959)
Lloyd H. Gaston, M.D., St. Luke's Hospital, New York 25 (1958)
Edna S. Lepper, R.N., Massachusetts General Hospital, Boston 14 (1959)
John B. Neilson, M.D., Hamilton General Hospitals, Hamilton, Ont. (1958)
Leon C. Pullen Jr., Decatur and Macon County Hospital, Decatur, Ill. (1960)
W. W. Stadel, M.D., San Diego County General Hospital, San Diego 3, Calif. (1959)
Secretary: LeRoy E. Bates, M.D., American Hospital Association, 18 E. Division St., Chicago 10

Committee on Chronic Illness

W. W. Stadel, M.D., *chairman*, San Diego County General Hospital, San Diego 3, Calif.
Irvin J. Cohen, M.D., Veterans Administration, Washington 25
Michael M. Dacso, M.D., Goldwater Memorial Hospital, Welfare Island, New York 17
David Littauer, M.D., Jewish Hospital, St. Louis 10
Edna E. Nicholson, Institute of Medicine of Chicago, 86 E. Randolph St., Chicago 1

Committee on Nursing

T. Stewart Hamilton, M.D., *chairman*, Hartford Hospital, Hartford 15, Conn. (1959)
Dean A. Clark, M.D., Massachusetts General Hospital, Boston 14 (1958)
Rev. John J. Flanagan, S.J., Catholic Hospital Association, 1438 S. Grand Blvd., St. Louis 4 (1960)
Thomas Hale Jr., M.D., Albany Hospital, Albany 8, N. Y. (1960)
Hugo V. Hullerman, M.D., Children's Hospital, Detroit 2 (1960)
Leo M. Lyons, American Protestant Hospital Association, 105 W. Adams St., Chicago 3 (1959)
Oliver G. Pratt, Rhode Island Hospital, Providence 2, R. I. (1958)
Leon C. Pullen Jr., Decatur and Macon County Hospital, Decatur, Ill. (1960)

Committee on Use of Radioisotopes in Hospitals

Richard D. Vanderwarker, *chairman*, Memorial Center for Cancer and Allied Diseases, New York 21
Paul Aebersold, Ph.D., Division of Civilian Application, Atomic Energy Commission, Oak Ridge, Tenn.
Alexander H. Bacci, Schmidt, Garden & Erikson, 104 S. Michigan Ave., Chicago 3
J. W. J. Carpender, M.D., University of Chicago Clinics, Chicago 37
Maj. Gen. James Cooney, deputy surgeon general, Department of the Army, Washington 25
Harry D. Bruner, M.D., Division of Biology & Medicine, Atomic Energy Commission, Washington 25
Frank E. Hoecker, Ph.D., University of Kansas, Lawrence, Kans.
Clinton C. Powell, M.D., Bureau of State Services, Public Health Service, Washington 25
Benjamin L. Smith, Voorhees, Walker, Smith & Smith, 101 Park Ave., New York 17
James G. Terrill Jr., Radiological Health Programs, Public Health Service, Washington 25

Committee to Prepare a Statement on the Joint Conference Committee

T. Stewart Hamilton, M.D., *chairman*, Hartford Hospital, Hartford 15, Conn.
Kenneth B. Babcock, M.D., Joint Commission on Accreditation of Hospitals, 660 N. Rush St., Chicago 11
Rev. John J. Flanagan, S.J., Catholic Hospital Association, 1438 S. Grand Blvd., St. Louis 4
Karl S. Klicka, M.D., Presbyterian-St. Luke's Hospital, Chicago 12
Robert Myers, M.D., American College of Surgeons, 40 E. Erie St., Chicago 11
Edward L. Turner, M.D., American Medical Association, 535 N. Dearborn St., Chicago 10

Committee to Revise Manual on Management of Tuberculosis in Hospitals

Edward T. Blomquist, M.D., Public Health Service, Washington 25
I. D. Bobrowitz, M.D., New York City Department Hospitals, New York 13
Sheila Dwyer, R.N., School of Practical Nursing, Miners' Memorial Hospital Association, Williamson, W. Va.
Frank T. Jones, Maryland Tuberculosis Association, 900 St. Paul, Baltimore 2
James E. Perkins, M.D., National Tuberculosis Association, 1790 Broadway, New York 17
Doris E. Roberts, R.N., Division of Special Health Services, Public Health Service, Washington 25

Representatives to Joint Committees of Other Groups

Joint Committee with American Association of Nurse Anesthetists
Robert R. Cadmus, M.D., *chairman* of AHA group, North Carolina Memorial Hospital, Chapel Hill, N. C. (1958)
Isadore S. Geeter, M.D., Mt. Sinai Hospital, Hartford 12, Conn. (1958)
F. Lloyd Mussells, M.D., Philadelphia General Hospital, Philadelphia 4 (1959)

Joint Committee with American College of Radiology
Gerhard Hartman, Ph.D., *chairman* of AHA group, State University of Iowa Hospitals, Iowa City, Iowa (1958)
George A. W. Currie, M.D., University of Texas Medical Branch Hospitals, Galveston, Tex. (1959)
Morris H. Kreeger, M.D., Michael Reese Hospital, Chicago 16 (1958)
George H. Vandusen, D.D.S., Christian Welfare Hospital, East St. Louis, Ill. (1959)

Joint Committee with American Dietetic Association
George E. Cartmill Jr., *chairman* of AHA group, Harper Hospital, Detroit 1 (1958)
H. Robert Cathcart, Pennsylvania Hospital, Philadelphia 7 (1959)
Taylor Coleman, Sharon Hospital, Sharon, Conn. (1959)
G. Otis Whitecotton, M.D., Highland-Alameda County Hospitals, Oakland 6, Calif. (1958)

Joint Committee with American Physical Therapy Association
H. Worley Kendell, M.D., *chairman* of AHA group, Institute of Physical Medicine and Rehabilitation, 619 N. Glen Oak Ave., Peoria 6, Ill. (1958)
George Silver, M.D., Montefiore Hospital, New York 67 (1958)
David Littauer, M.D., Jewish Hospital, St. Louis 10 (1959)

Joint Committee with American Society of Hospital Pharmacists
Robert R. Cadmus, M.D., *chairman* of AHA group, North Carolina Memorial Hospital, Chapel Hill, N. C. (1958)
C. P. Cardwell Jr., Medical College of Virginia, Hospital Division, Richmond, Va. (1959)
Joe Vance, South Highlands Infirmary, Birmingham 5, Ala. (1958)
John J. Zugich, University Hospital, Ann Arbor, Mich. (1959)

Joint Committee with College of American Pathologists
C. C. Hillman, M.D., *chairman* of AHA group, 223 S.E. First St., Miami 32, Fla. (1958)
Philip D. Bonnet, M.D., Massachusetts Memorial Hospitals, Boston 18 (1959)
Lloyd H. Gaston, M.D., St. Luke's Hospital, New York 25 (1960)

Joint Committee with Medical Social Work Section of National Association of Social Workers
Morris H. Kreeger, M.D., *chairman* of AHA group, Michael Reese Hospital, Chicago 16 (1958)
Delbert L. Price, Children's Memorial Hospital, Chicago 14 (1958)
Brigadier Jane E. Wrieden, Booth Memorial Hospital, Cleveland 12 (1959)
Peter B. Terenzio, Roosevelt Hospital, New York 19 (1959)

Joint Committee on Paramedical Groups
Thomas Hale Jr., M.D., Albany Hospital, Albany 8, N. Y.
Stuart K. Hummel, Columbia Hospital, Milwaukee 11
Carl C. Lamley, Stormont-Vail Hospital, Topeka, Kans.

Joint Committee for the Study of Surgical Materials
LeRoy E. Bates, M.D., American Hospital Association, 18 E. Division St., Chicago 10

Liaison Committee with American Psychiatric Association
Jack Masur, M.D., *chairman* of AHA group, assistant surgeon general, Public Health Service, Clinical Center, Bethesda 14, Md.
LeRoy E. Bates, M.D., American Hospital Association, 18 E. Division St., Chicago 10
Richard O. Cannon, M.D., Vanderbilt University Hospital, Nashville 5, Tenn.
Edwin L. Crosby, M.D., American Hospital Association, 18 E. Division St., Chicago 10
James T. Howell, M.D., Henry Ford Hospital, Detroit 2

National Joint Commission for the Improvement of the Care of the Patient
Oliver G. Pratt, *chairman* of the AHA group, Rhode Island Hospital, Providence 2, R. I. (1958)
Rev. John J. Flanagan, S.J., Catholic Hospital Association, 1438 S. Grand Blvd., St. Louis 4 (1960)
Thomas Hale Jr., M.D., Albany Hospital, Albany 8, N. Y. (1958)
Hugo V. Hullerman, M.D., Children's Hospital, Detroit 2 (1960)
Leo M. Lyons, American Protestant Hospital Association, 105 W. Adams St., Chicago 3 (1959)
Leon C. Pullen Jr., Decatur and Macon County Hospital, Decatur, Ill. (1959)

Representatives to Other Organizations

Advisory Board for Medical Specialties
Robin C. Buerki, M.D., Henry Ford Hospital, Detroit 2
Edwin L. Crosby, M.D., American Hospital Association, 18 E. Division St., Chicago 10

Liaison to Standards Committee of American Committee on Maternal Welfare
Edwin L. Harmon, M.D., Grasslands Hospital, Valhalla, N. Y.

Commission on Professional and Hospital Activities, Inc.
Edwin L. Crosby, M.D., American Hospital Association, 18 E. Division St., Chicago 10 (1958)
Maurice J. Norby, American Hospital Association, 18 E. Division St., Chicago 10

Educational Council for Foreign Medical Graduates
T. Stewart Hamilton, M.D., Hartford Hospital, Hartford 15, Conn., trustee (1960)
Sarah Hardwicke Knutti, M.D., Glen Rd., Rockville, Md. (1961)

Joint Blood Council, Inc.
LeRoy E. Bates, M.D., American Hospital Association, 18 E. Division St., Chicago 10, director and alternate delegate (1958)
Roger W. DeBusk, M.D., Grace Hospital, Detroit 1, director and delegate (1959)

Joint Commission on Mental Illness and Health
Russell A. Nelson, M.D., Johns Hopkins Hospital, Baltimore 5

National Intern Matching Program, Inc.
Edwin L. Crosby, M.D., American Hospital Association, 18 E. Division St., Chicago 10
Karl S. Klicka, M.D., Presbyterian-St. Luke's Hospital, Chicago 12

Representatives to Committees of Other Organizations

Ad hoc Committee of American Nurses' Association and National League for Nursing on Maternal and Child Health Nursing
Hilda H. Kroeger, M.D., Elizabeth Steel Magee Hospital, Pittsburgh 13

Ad hoc Advisory Committee on Post-Graduate Medical Education of Council on Medical Education and Hospitals, American Medical Association
James T. Howell, M.D., Henry Ford Hospital, Detroit 2

Advisory Board of American Registry of Physical Therapists
Merrill F. Steele, M.D., Bethesda Memorial Hospital, Delray Beach, Fla.

Advisory Committee of National Committee for Careers in Medical Technology
John Bowden, M.D., U.S. Public Health Service Hospital, Staten Island 4, N. Y.

Advisory Committee on Civilian Utilization of Military Training and Experience in Nursing of National League for Nursing
Marian L. Fox, R.N., American Hospital Association, 18 E. Division St., Chicago 10

Advisory Committee on the Costs of Nursing Education of National League for Nursing
Hugo V. Hullerman, M.D., Children's Hospital, Detroit 2

Advisory Council on Medical Education
Robin C. Buerki, M.D., Henry Ford Hospital, Detroit 2
Edwin L. Crosby, M.D., American Hospital Association, 18 E. Division St., Chicago 10
Russell A. Nelson, M.D., Johns Hopkins Hospital, Baltimore 5

Advisory Council on National Federation of Licensed Practical Nurses
Edna S. Lepper, R.N., Massachusetts General Hospital, Boston 14 (1958)

Committee on Careers, National League for Nursing, Representing the National Nursing Organizations
Mrs. Frederick N. Blodgett (Address: Claybrook Rd., Dover, Mass.), Ladies Committee, New England Medical Center, Boston 11
James E. Hague, American Hospital Association, 18 E. Division St., Chicago 10
Alfred Marshall, Grace-New Haven Community Hospital, New Haven 4, Conn.

Committee on Education and Registration of American Association of Medical Record Librarians
Mrs. Helen D. McGuire, American Hospital Association, 18 E. Division St., Chicago 10

Committee on Meeting Nursing Needs of the Mentally Ill, Advisory to American Nurses' Association-National League for Nursing
James T. Howell, M.D., Henry Ford Hospital, Detroit 2

Committee on Nursing Service and Education in National Defense, National League for Nursing
William H. Flannagan, Roanoke Memorial Hospital, Roanoke, Va.

Committee on Operating Rooms of National Fire Protection Association
Roy Hudenburg, Community Health Association, 8143 E. Jefferson Ave., Detroit 14
Albert H. Scheidt, Dallas County Hospital District, Dallas 19, Tex.

Council on Tuberculosis Nursing-Advisory to Joint Tuberculosis Nursing Advisory Service for National League for Nursing and National Tuberculosis Association
Gordon M. Meade, M.D., Miners Memorial Hospital Association, Washington 5

Executive Committee on Accreditation Policies of National League for Nursing
Laurence J. Bradley, Genesee Hospital, Rochester 7, N. Y.
Rt. Rev. Msgr. Edmund J. Goebel, archdiocesan director of hospitals, 437 W. Galena, Milwaukee 12
Hugo V. Hullerman, M.D., Children's Hospital, Detroit 2
Leo M. Lyons, American Protestant Hospital Association, 105 W. Adams, Chicago 3
William L. Wilson, Mary Hitchcock Memorial Hospital, Hanover, N. H.

Hospital Advisory Committee of National Association for Practical Nurse Education
Leo M. Lyons, American Protestant Hospital Association, 105 W. Adams St., Chicago 3

Hospital Nursing Service Liaison Committee with National League for Nursing
(Same as Committee on Nursing)

Inter-Industry Committee of American Hotel Association
Ruth Kahn, American Hospital Association, 18 E. Division St., Chicago 10
Richard D. Vanderwarker, Memorial Hospital for Cancer and Allied Diseases, New York 21

Internship Review Committee of Council on Medical Education and Hospitals of American Medical Association
Russell A. Nelson, M.D., Johns Hopkins Hospital, Baltimore 5

National League for Nursing Accrediting Service, Department of Diploma and Associate Degree Programs Review Board
Rev. W. C. Perdew, D.D., Bronson Methodist Hospital, Kalamazoo 8, Mich.

Sectional Committee on Reactor Hazards of American Society of Mechanical Engineers
James G. Terrill Jr., Radiological Health Program, Public Health Service, Washington 25

COUNCIL ON RESEARCH AND EDUCATION

E. Dwight Barnett, M.D., *chairman*, School of Public Health and Administrative Medicine, Columbia University, New York 32
Philip D. Bonnet, M.D., *vice chairman*, Massachusetts Memorial Hospitals, Boston 18 (1959)
Brig. Gen. Elbert DeCoursey, MC, USA, Army Medical Service School, Fort Sam Houston, Tex. (1958)
Nelson F. Evans, University Hospital, Little Rock, Ark. (1959)
Celeste Kemler, Valley View Hospital, Ada, Okla. (1960)
A. C. Kerlikowske, M.D., University Hospital, Ann Arbor, Mich. (1958)
J. Dewey Lutes, Woonsocket Hospital, Woonsocket, R. I. (1960)
Harry M. Malm, Lutheran Hospital and Home Society, Call Bldg., Torrington, Wyo. (1960)
R. C. Williams, M.D., State of Georgia Department of Public Health, Atlanta 3 (1958)
Harold A. Zealley, Elyria Memorial Hospital, Elyria, Ohio (1959)
Secretary: Daniel S. Schechter, American Hospital Association, 18 E. Division St., Chicago 10

Committee on Library Service for Hospitals
James W. Stephan, *chairman*, University of Minnesota, Minneapolis 14
Bob D. Dann, Hackley Memorial Hospital, Muskegon, Mich.
Henry J. Gartland, Veterans' Administration, Library Division, Washington 25
Robert Guy, Baton Rouge General Hospital, Baton Rouge 9, La.
Jack A. L. Hahn, Methodist Hospital, Indianapolis 7
Zella Messner, R.N., Hospital Facilities Section, South Dakota Department of Health, Pierre, S. Dak.

Representatives of Other Organizations

Council of National Organizations of Adult Education Association of the United States
Daniel S. Schechter, American Hospital Association, 18 E. Division St., Chicago 10

Joint Committee with American College of Hospital Administrators and Association of University Programs in Hospital Administration
Richard R. Griffith, Delaware Hospital, Wilmington 1, Del.
Oliver G. Pratt, Rhode Island Hospital, Providence 2, R. I.
Cecil G. Sheps, M.D., Beth Israel Hospital, Boston 15

EXECUTIVE STAFF

Director
Edwin L. Crosby, M.D., Headquarters

Deputy Director
Maurice J. Norby, Headquarters

Associate Directors
Madison B. Brown, M.D., Headquarters
Kenneth Williamson, Washington Service Bureau

Headquarters Address: 18 E. Division St., Chicago 10

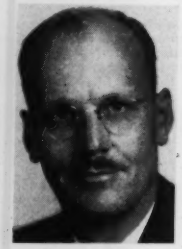
Washington Service Bureau Address: Mills Bldg., 17th St. and Pennsylvania Ave., Washington 6

Newly appointed chairmen, vice chairmen and members of the American Hospital Association councils

A complete listing of officers and appointments of the AHA begins on page 21. Pictures of new AHA officers and trustees appeared in the Oct. 16 issue of this Journal (pp. 60-61)

Council on Administrative Practice

STANLEY A. FERGUSON
Chairman
Dir., University Hospitals of Cleveland



J. MILO ANDERSON
Vice Chairman
Adm., Strong Memorial Hospital, Rochester, N.Y.

HORACE M. CARDWELL
Adm., Memorial Hospital, Lufkin, Texas

JAMES M. CREWS
Adm., Methodist Hospital, Memphis, Tenn.

GEORGE A. HAY
Adm., Hospital of the Women's Medical College of Pennsylvania

RILEY McDAVID
Adm., Kenosha Hospital, Kenosha, Wis.

CLYDE L. SIBLEY
Adm., Birmingham Baptist Hospital, Birmingham, Ala.

Council on Association Services

BOONE POWELL
Chairman
Adm., Baylor University Hospital, Dallas, Texas

PAT N. GRONER
Vice Chairman
Adm., Baptist Hospital, Pensacola, Fla.

LEO M. LYONS
Exec. Dir., American Protestant Hospital Association, Chicago

ROY R. PRANGLEY
Adm., St. Luke's Hospital, Denver, Colo.

ABRAM L. VAN HORN, M.D.
Med. Dir., Kate Macy Ladd Convalescent Home, Far Hills, N.J.

Council on Government Relations

ROBIN C. BUERKI, M.D.
Chairman
Exec. Dir., Henry Ford Hospital, Detroit

WILLIAM L. WILSON
Vice Chairman
Adm., Mary Hitchcock Memorial Hospital, Hanover, N.H.

HARRY E. PANHORST
Assoc., Dir., Barnes Hospital St. Louis

HAROLD PRATHER
Adm., Richmond Memorial Hospital, Richmond, Va.

KENNETH WALLACE
Asst. Adm., St. John's Hospital, Tulsa, Okla.

Council on Hospital Auxiliaries

MRS. CHESTER A. HOOVER
Chairman
Santa Monica Hospital, Santa Monica, Calif.

MRS. PALMER GAILLARD JR.
Vice Chairman
Mobile Infirmary, Mobile, Ala.

MRS. COLUMBUS CONBOY
St. Joseph Infirmary, Louisville, Ky.

MRS. SINTON P. HALL
Children's Hospital, Cincinnati

GUY M. HANNER
Adm., Good Samaritan Hospital, Phoenix, Ariz.

MRS. HARRY MILTON
Jewish Hospital of St. Louis, St. Louis

MISS LAURA VOSSLER
Director of Volunteers, Presbyterian Hospital in the City of New York

Council on Planning, Financing and Prepayment

DAVID B. WILSON, M.D.
Chairman
Dir., University Hospital, Jackson, Miss.

JAMES M. DANIEL
Vice Chairman
Supt., Columbia Hospital of Richland County, Columbia, S.C.

ALFRED PAUL BAY, M.D.
Supt., Topeka State Hospital, Topeka, Kans.

JAY W. COLLINS
Exec. Dir., Euclid-Glenville Hospital, Euclid, Ohio

COMDR. L. J. ELSASSER, MSC, USN
Commanding Officer, Naval School of Hospital Administration, National Naval Medical Center, Bethesda, Md.

Council on Planning, Financing and Prepayment (Continued)

HERMAN L. HEROLD
Adm., North Louisiana Sanitarium,
Shreveport, La.

WESLEY G. LAMER
Adm., Physicians and Surgeons Hospital,
Portland, Ore.

SIDNEY LISWOOD
Adm., New Mount Sinai Hospital,
Toronto, Ontario, Canada

DELBERT L. PUGH
Exec. Dir., Columbus Hospital Federation,
Columbus, Ohio

SISTER MARY VINCENT, R.N.
Adm., St. Joseph's Hospital,
Fort Worth, Texas

Council on Professional Practice

RUSSELL A. NELSON, M.D.
Chairman
Dir., Johns Hopkins Hospital,
Baltimore

T. STEWART HAMILTON, M.D.
Vice Chairman
Dir., Hartford Hospital,
Hartford, Conn.

LOUIS B. BLAIR
Supt., St. Luke's Methodist Hospital,
Cedar Rapids, Iowa

JOHN B. NEILSON, M.D.
Supt. Hamilton General Hospitals,
Hamilton, Ontario, Canada

LEON C. PULLEN JR.
Adm., Decatur and Macon County Hospital,
Decatur, Ill.

Council on Research and Education

E. DWIGHT BARNETT, M.D.
Chairman
Prof. Adm. Med., School of Public Health and Administrative Medicine
Columbia University,
New York

PHILIP D. BONNET, M.D.
Vice Chairman
Adm., Massachusetts Memorial Hospitals,
Boston

BRIG. GEN. ELBERT DeCOURSEY, MC, USA
Commandant, Army Medical Service School,
Fort Sam Houston, Texas

NELSON F. EVANS
Adm., University Hospital,
Little Rock, Ark.

CELESTE K. KEMLER
Adm., Valley View Hospital,
Ada, Okla.

A. C. KERLIKOWSKE, M.D.
Dir., University Hospital,
Ann Arbor, Mich.

J. DEWEY LUTES
Supt., Woonsocket Hospital,
Woonsocket, R.I.

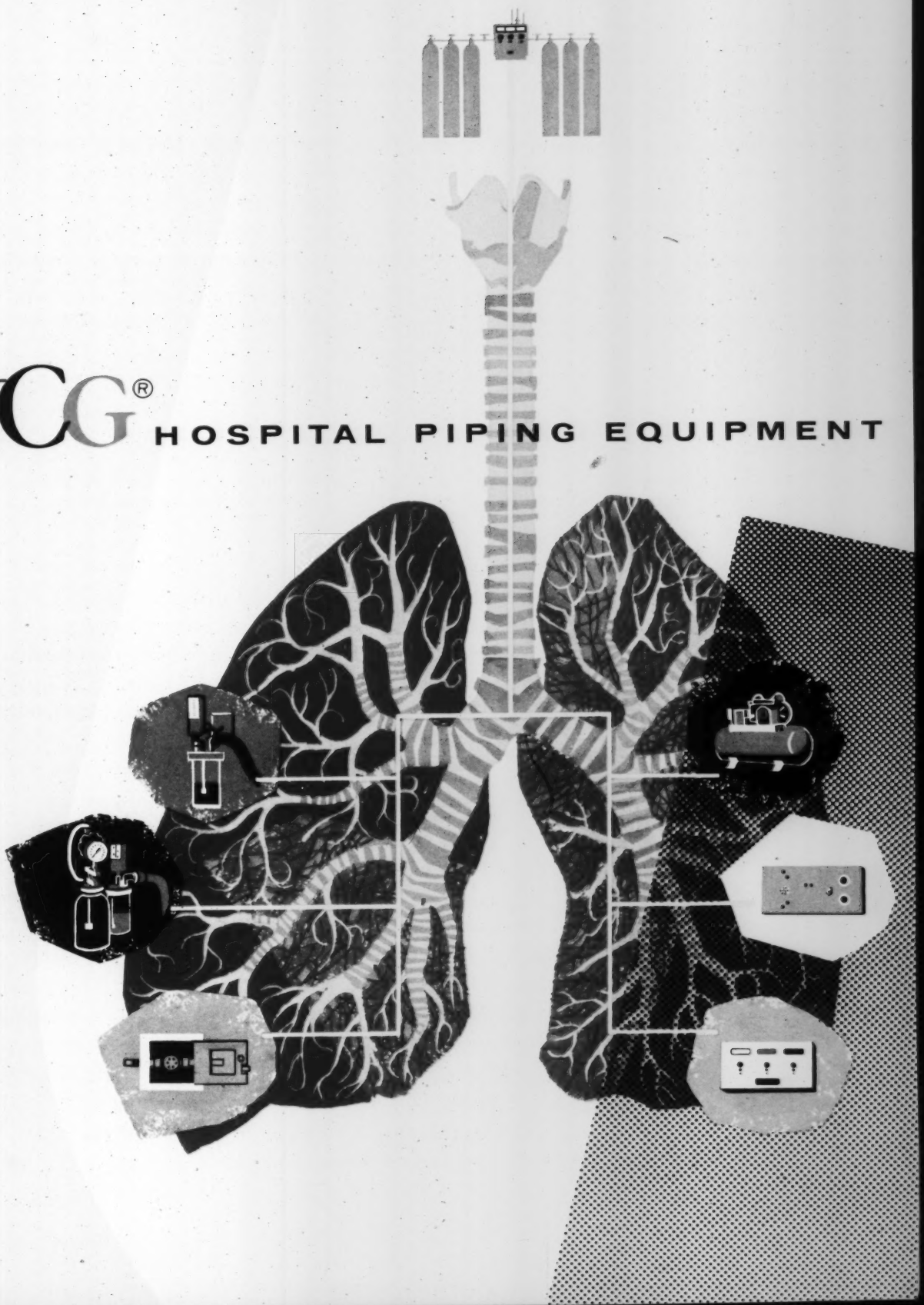
HARRY M. MALM
Area Director,
Lutheran Hospitals and Homes Society,
Torrington, Wyo.

R. C. WILLIAMS, M.D.
Dir., Hospital Facilities Program, State of Georgia Department of Public Health,
Atlanta

HAROLD A. ZEALLEY
Adm., Elyria Memorial Hospital,
Elyria, Ohio

NCG®

HOSPITAL PIPING EQUIPMENT



NCG®

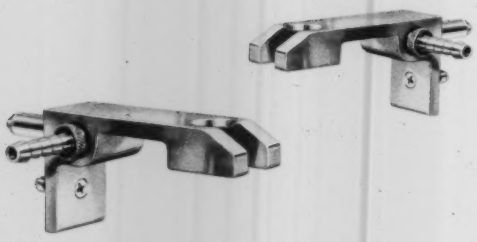
HOSPITAL PIPING EQUIPMENT

helps hospitals to breathe easier...

With NCG piping systems, medical gases, and piping equipment, hospitals can feel assured that they are providing the best in inhalation therapy—NCG has a habit of being *first* with the best: *first* completely automatic manifold control unit, *first* completely flush outlet, *first* flowmeter made of nylon, *first* flowmeter made especially for nurseries . . . the list is long. Illustrated below is *more* new NCG equipment, as featured in catalog NM-192—available from your NCG representative or from address below.

NEW MULTIPLE OUTLET

Vacuum and oxygen outlet for recovery and delivery rooms designed so that vacuum and oxygen equipment can be mounted on it side by side and used at the same time.



NEW BOTTLE HOLDER VACUUM ADAPTER

This new vacuum adapter serves as its own bottle holder. It locks into position with a single easy thrust so the vacuum system can be used immediately. It secures the vacuum bottle and regulator in an upright position so that it cannot be knocked over or accidentally disengaged from the outlet opening. It is equipped with a valve that can be closed when unit is not in use. Valve can also be removed and reversed, as shown in illustration, so that inlet is on either right or left side.

NEW TAMPER-PROOF ADAPTER

Recommended for psychiatric divisions, nurseries, recovery rooms, and general wards. This new adapter has a positive locking mechanism with a key. The adapter chain can be easily attached to the standard outlet, and when inserted and locked in the outlet, it prevents anyone from tampering with the outlet station when not in use. For oxygen or vacuum, complete with key.

NCG®

NATIONAL CYLINDER GAS COMPANY

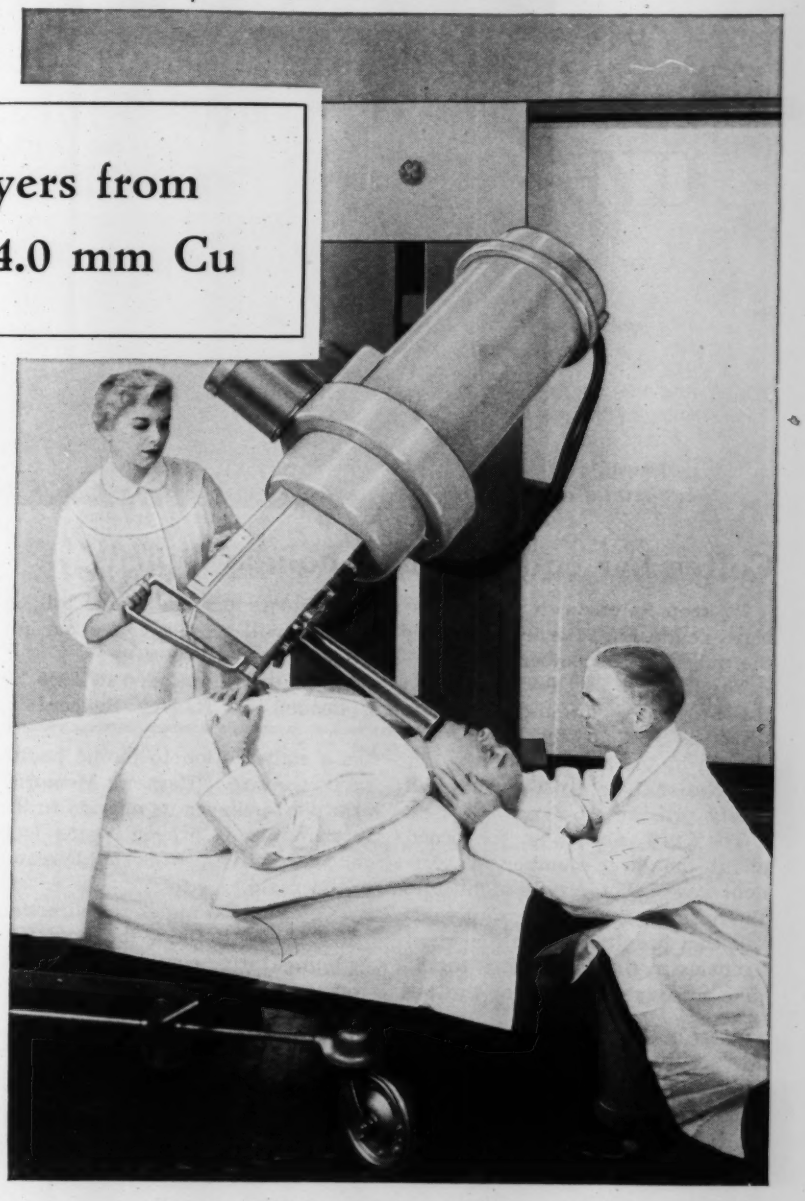
840 North Michigan Avenue, Chicago 11, Illinois

Offices in 56 Cities

©1957, National Cylinder Gas Company

NEW MAXITRON® 300 / *a General Electric therapy unit in step with your progress*

Half-value layers from .25 mm Al to 4.0 mm Cu



From General Electric comes a new x-ray unit that offers unapproached flexibility for superficial, intermediate and deep therapy. Thanks to its beryllium window and electronic power supply, the Maxitron 300 produces a high dose rate over an extremely wide range of half-value layers. Here are just a few of its many new features:

- **NEW HIGH RATING** — 300 kvp, 20 ma — for shorter treatment schedules . . . with higher-quality radiation.
- **NEW DIAL-THE-TECHNIC CONTROL** — Set a dial on the control console for any of 10 half-value layers. The proper filter shifts into place, and matching kvp and ma settings are established — *all automatically.*
- **NEW UNIVERSAL TUBE-HEAD MOVEMENT** — anywhere within a 72-in. length, 38-in. width, 54-in. height *without disturbing the patient.*
- **NEW POSITIONING ACCURACY** — Electrical locks with fingertip controls independently lock and unlock each of the six tube-head and tube-stand motions.
- **NEW VISUAL LOCALIZER** with an accurate, easily seen, adjustable beam — from complete closure to a 20 x 20 cm field at a focal-skin distance of 50 cm — adds *no* filtration.
- **NEW PROVISION FOR ROTATIONAL THERAPY** offers a continuously alternating rotational motion of focal spot up to 360°. Two on-off radiation arcs without tube build-up.

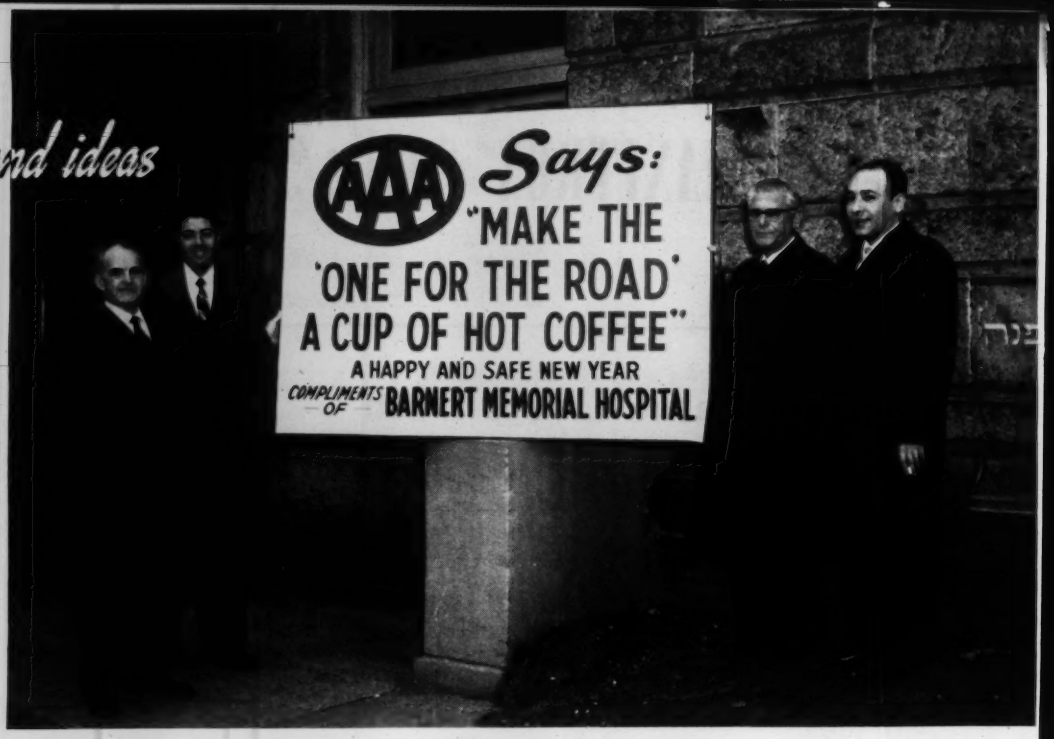
Your General Electric x-ray representative can tell you about the many other new, improved features of the Maxitron 300. Call him, or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, Room L-112.

Progress Is Our Most Important Product

GENERAL ELECTRIC

©1957, National Cylinder Gas Company

opinions and ideas



Coffee bar cuts down on holiday 'spirits'

To keep Paterson, N. J., streets safe and to reduce the traffic toll on New Year's Eve, Barnert Memorial Hospital will open a coffee bar for the public on December 31.

The idea for the New Year's Eve coffee bar was developed in 1955 by the hospital's administrative council, headed by Harvey Schoenfeld, director. The project is an outgrowth of the staff's desire to aid the National Safety Council road safety program.

The staff, also, was concerned about the large number of accident cases that are brought into the hospital on New Year's Eve. It felt that hospitals as well as other agencies in the community should take measures to prevent the toll as a contribution to public health and welfare. "Barnert Memorial Hospital believes its mission to the community is preventive as well as corrective," reports Director Schoenfeld.

Late in 1955 under the direction of Norman Bolotin, the hospital's administrative controller, the local office of the American Automobile Association was contacted to advertise and sponsor the project. The organization was immediate in its enthusiasm and support.

Large signs were prepared and placed strategically to attract motorists to the area. The hospital's station wagon was readied to serve as a mobile canteen. Coffee and cookies were prepared by the hospital's dietary department.

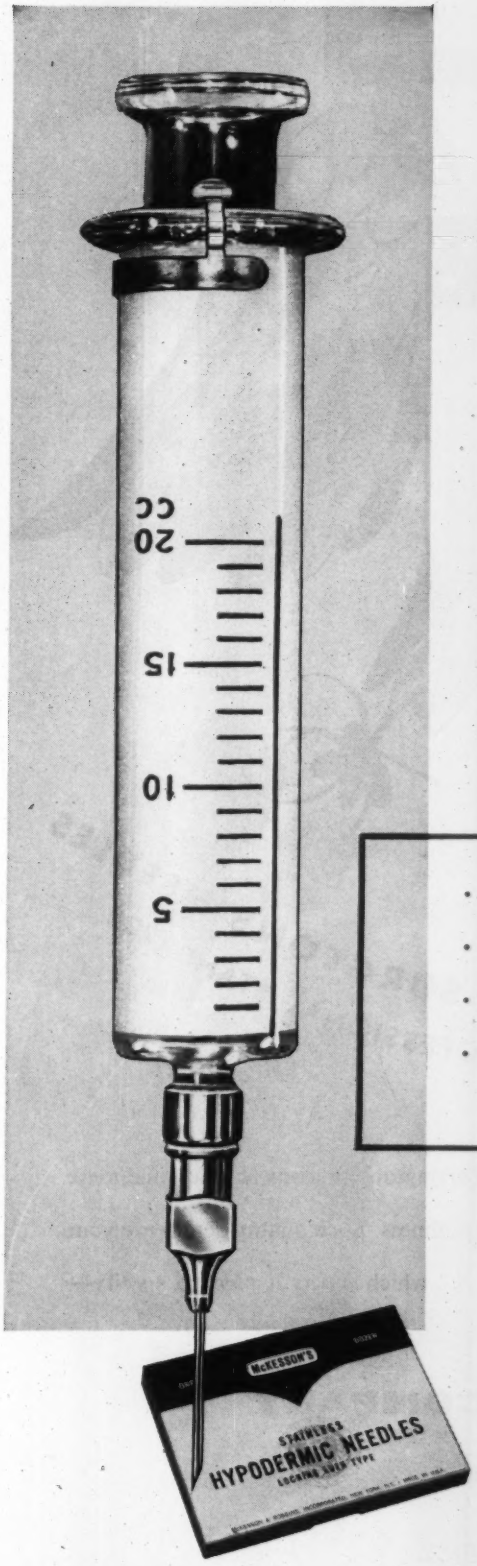
To staff the canteen, the hospital's volunteer department called upon the community to give time to this project. A number of persons volunteered for duty from 10 p.m. until 3 a.m.

As a further reminder of the need for caution and careful driving, the hospital ambulance was stationed in front of the hospital with its lights flashing. This attracted additional persons to the scene.

Last New Year's Eve the hospital was joined by the local Boy Scouts in the coffee bar project. They provided a special tent, which was set up on the hospital's front lawn.

Approximately 50 persons stopped to use the coffee bar. "Although this project may be a small contribution to the over-all national picture," Director Schoenfeld said, "hospital personnel felt a great sense of satisfaction in playing a part in it." ■

BARNERT Memorial Hospital, Paterson, N. J., will again sponsor a coffee bar for the public on New Years' Eve. This is the third year that the hospital has arranged for the service. In 1955 the local office of the American Automobile Association assisted in the preparation of signs (above) and last year the local Boy Scouts supplied a tent (below).



AN INVITATION
TO COMPARE McKESSON'S
NEW, COMPLETE LINE OF

HYPODERMIC SYRINGES AND NEEDLES

Compare them, price for price, quality for quality, with any other premium syringes

No matter what hypodermic syringes and needles you are now using, we invite you to compare. Quality for quality—price for price.

Consistent Superior Quality . . . Exacting high inspection standards of raw materials and during production insures surpassing of government specifications at all times.

Special Service! Available locally through 78 McKesson warehouses completely stocked from coast to coast, you have almost instantaneous service in emergencies.

New Savings! . . . On your bookkeeping and delivery costs when you order from one source, with one set of bills, from the nearby local McKesson house now serving you in many other ways.

EXAMINE THESE ADVANCED FEATURES

- Barrel markings and dosage line on plunger are indelibly embedded *into* the glass. Syringes can be autoclaved indefinitely.
- McKesson's hypodermic syringes have all graduations in red for highest visibility.
- Interchangeable plungers fit perfectly into any McKesson syringe of the same size. Replacements may be ordered separately.
- Stainless steel needles: tough, strong and highly corrosion-resistant. Each point is carefully hand-finished and honed. The McKesson needle, which comes with long or short bevel, fits all Luer-tapered syringe tips.

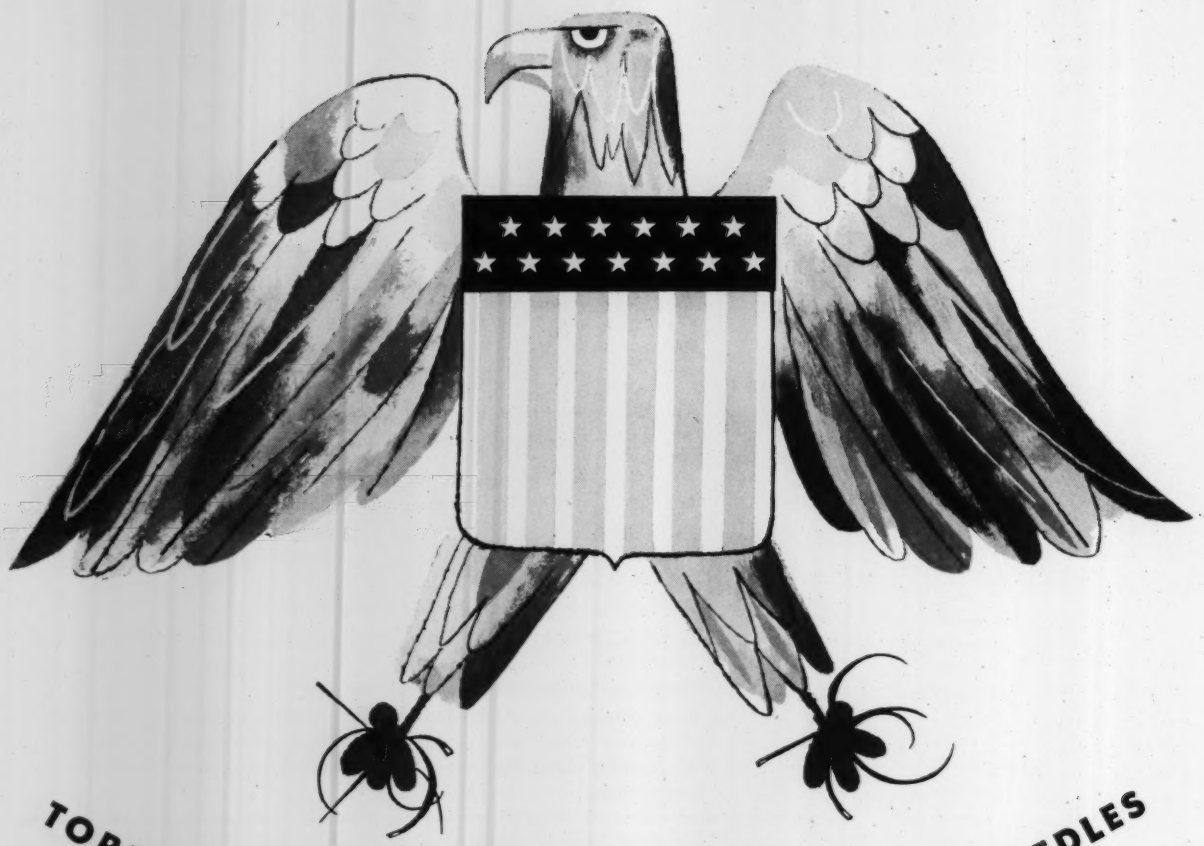
COMPARE! *Now that you have the facts, see for yourself! Arrange today for a trial supply with your local McKesson representative. Or write!*

HOSPITAL DEPARTMENT,
McKesson & Robbins, Inc.
155 E. 44th St.
New York 17, N. Y.

HOSPITAL DEPARTMENT
McKESSON & ROBBINS INC.

Serving America's Hospitals

BETTER . . . *by* McKESSON



TORRINGTON STAINLESS STEEL SURGEONS NEEDLES

ARE MADE IN AMERICA TO HIGHEST PROFESSIONAL STANDARDS

ONLY CORROSION-RESISTANT STAINLESS STEEL is used in Torrington Surgeons Needles, and these needles are polished to an extra high gleam and perfect smoothness. Such quality details are your assurance of top performance and absolute dependability . . . which is why it pays to specify—and always insist on—TORRINGTON.

THE TORRINGTON COMPANY

Torrington, Conn.

Torrington's 91st Year of Dependable Service

ACE-HESIVE®

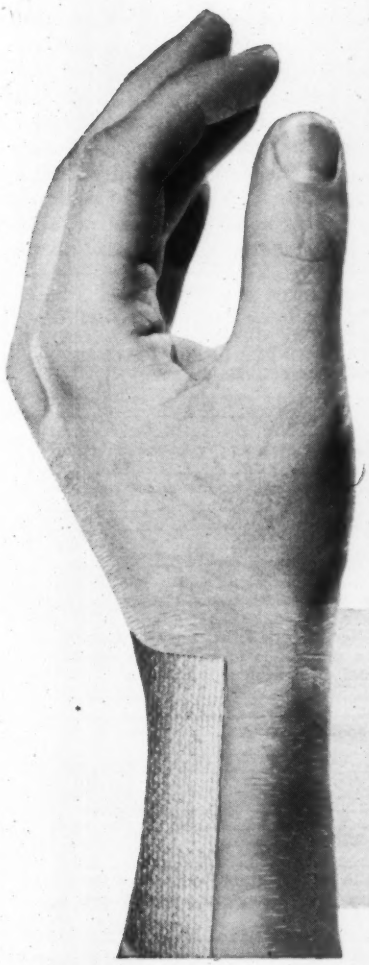
for elastic bandaging that stays in place

B-D

New B-D ACE-HESIVE provides the elasticity and support of famous B-D quality cotton elastic, plus the added strength and holding properties of a specially developed adhesive backing.

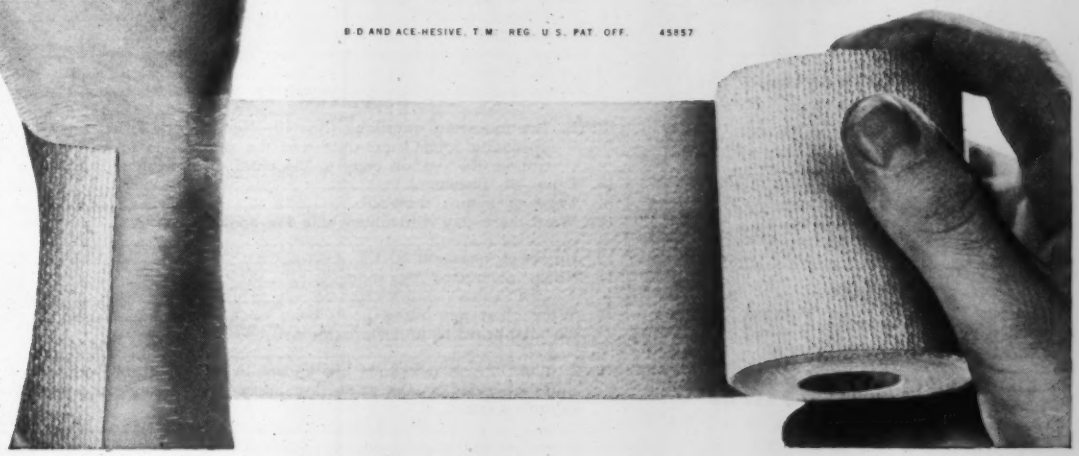
- unfailing support—will not slip or creep, even in hard-to-bandage areas
- sufficient elasticity—correct combination of stretch and tension ensures uniform pressure and ease of application
- minimum skin reaction—purest-grade ingredients practically assure freedom from skin sensitivity
- semipermeable—permits passage of air and excess exudates

ACE-HESIVE hospital package
12 bandages in individual, moisture-proof polyethylene bags, in 2", 2½", 3" and 4" widths.



BECTON, DICKINSON AND COMPANY · RUTHERFORD, NEW JERSEY

B-D AND ACE-HESIVE, T. M. REG. U. S. PAT. OFF. 45857



Onan
ELECTRIC PLANTS
ELECTRIC PLANT
NEWS

Power outages can do no harm in this hospital

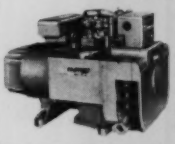
Onan Electric Plant supplies emergency power for lighting and all vital electrical equipment

An Onan Emergency Power System protects patients and personnel. Supplies current for lighting corridors, operating rooms, delivery rooms, stairways; provides power for heating system, ventilators, elevators, X-Ray machines, and other vital equipment.

Your hospital is assured of electric power at all times with Onan Emergency Electricity. *Operation is completely automatic.* When highline power is interrupted, the plant starts automatically; stops when power is restored.

Models for any size hospital—1,000 to 75,000 watts A.C.

Complete standby systems at lower cost



Onan Vacu-Flo cooling permits using *air-cooled* models in many installations at a considerable saving. Check Onan before you specify.

See your architect or engineer

Onan ELECTRIC PLANTS

Write for Standby Folder

D.W. ONAN & SONS INC.

3389 University Avenue S.E.
Minneapolis 14, Minnesota

accreditation problems

KENNETH B. BABCOCK, M.D.

- **reporting infections**
- **preparing histories and physicals**

We did approximately 2000 operations at our hospital last year and reported no infections of clean surgical cases. We were surprised when your surveyor questioned the accuracy of our reporting. What prompted his questioning?

Let us say congratulations first and then ask you to do some double checking. Frankly your statistics are almost too good to be true. We would suggest that the nurses on the floors be asked whether there are any surgical patients they have seen or known of with a stitch abscess or the presence of an exudate or transudate on the dressings of any clean surgical cases. We are sure that you will get some positive answers from the inquiries.

The weakness of the reporting usually lies in the lack of a definite procedure known to physicians, nurses, house staff, etc. A form used by one hospital with excellent results is included below as a suggestion.

We are a smaller hospital. The medical staff refuses to write a university-type history and physical as is required by the Joint Commission. Is it really necessary?

University-type history and physical on each patient is not necessary and it is not required by the Joint Commission on Accreditation of Hospitals. The Commission standards read: "There will be an adequate history and physical written on every patient."

The term "adequate" does not mean a definite number of lines or pages. It means that if the doctor on a case had to step out of it, the new doctor could intelligently carry on the care of this case without detriment to the patient and without a loss of continuity of time or treatment. It would mean that if this same patient left the hospital and returned five years later under the care of a third doctor, the former history, physical and progress notes would be meaningful and helpful to the new doctor.

WOUND INFECTION FORM

NOTE: TO BE FILLED OUT IN DUPLICATE (No. 1—No. 9) THE FOLLOWING QUESTIONS ARE FILLED IN BY THE HEAD NURSE ON ALL WOUND INFECTIONS OF CLEAN CASES AND THESE FORMS ARE TO BE SENT DIRECTLY TO THE OPERATING ROOM SUPERVISOR.

1. Name of operating surgeon
2. Date and hour of operation
3. Name of operation
4. Presence of any pyogenic skin infection in the patient or in the attending ward personnel
5. Presence of other patients with infected wounds in the same room or ward
6. Postoperative day on which the infection was discovered
7. Nature and amount of drainage
8. Were cultures made and what was the organism reported?
9. Were antibiotics used preoperatively or postoperatively or both?

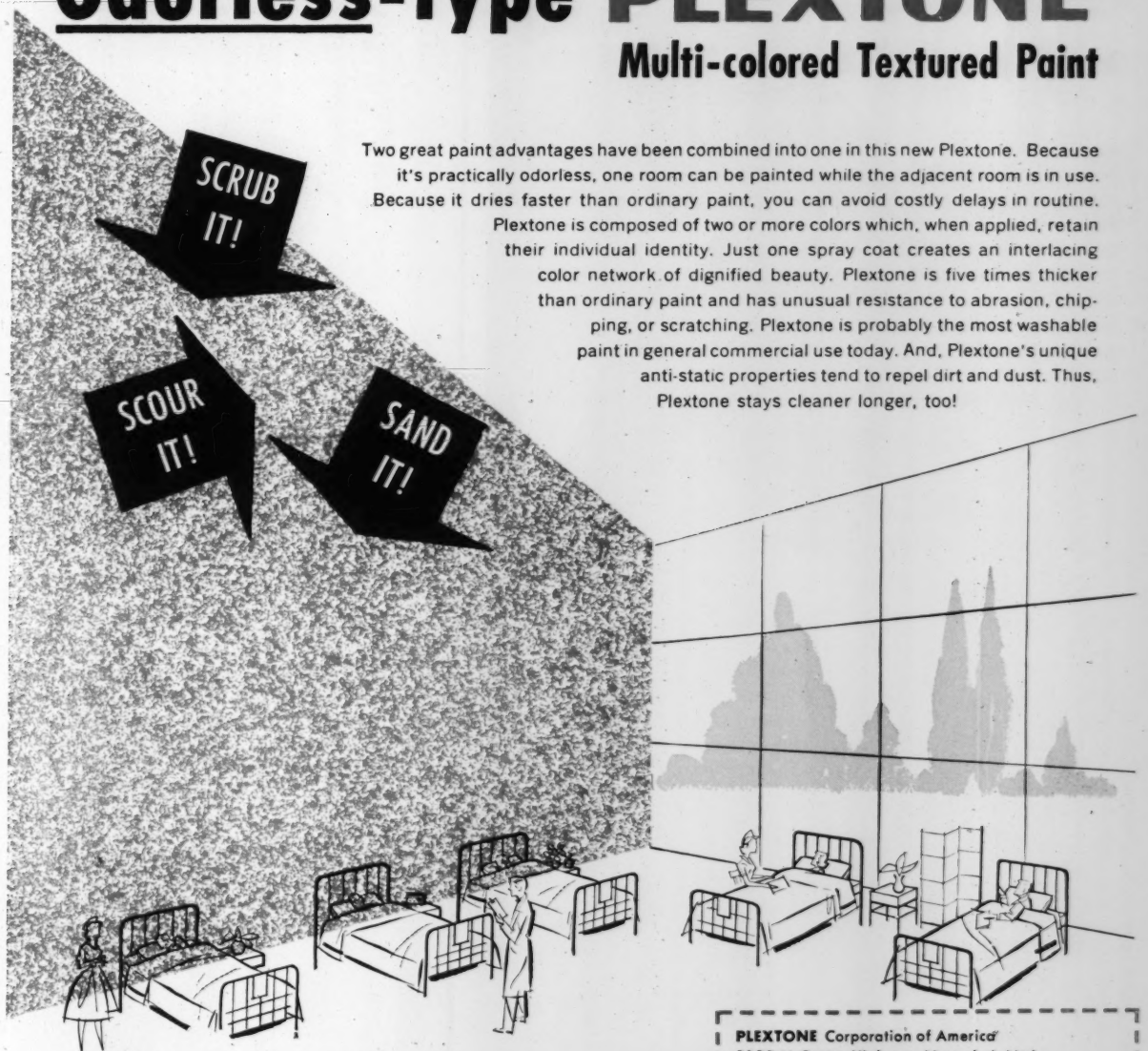
NOTE: The following questions (No. 10—No. 16) are to be answered by the operating room supervisor and the original is to be sent to administration, the carbon copy to the chief of division of surgery.

10. Type of incision
11. Type of suture material
12. Were there any difficulties with the sponge count?
13. Name of assistant
14. Name of nurses assisting
15. What other operations have been done in the same room on the same morning previous to this operation?
16. If other wound infections are known to have occurred on one of the patients operated on the same day, name the personnel concerned and the organism found.

NOW IT'S HERE!

Odorless-type PLEXTONE®

Multi-colored Textured Paint



Two great paint advantages have been combined into one in this new Plextone. Because it's practically odorless, one room can be painted while the adjacent room is in use. Because it dries faster than ordinary paint, you can avoid costly delays in routine. Plextone is composed of two or more colors which, when applied, retain their individual identity. Just one spray coat creates an interlacing color network of dignified beauty. Plextone is five times thicker than ordinary paint and has unusual resistance to abrasion, chipping, or scratching. Plextone is probably the most washable paint in general commercial use today. And, Plextone's unique anti-static properties tend to repel dirt and dust. Thus, Plextone stays cleaner longer, too!

PLEXTONE
Corporation of America

World's Largest Supplier of Multi-colored Textured Paints

2139 McCarter Highway, Newark 4, N.J.

Midwest Division: 1658 Carroll Avenue, Chicago 12, Ill.
Pacific Coast Division: 10751 Venice Blvd., Los Angeles 34, Calif.

PLEXTONE Corporation of America
2139 McCarter Highway, Newark 4, N. J.

Please rush free color-flecked PLEXTONE color chips and application data.

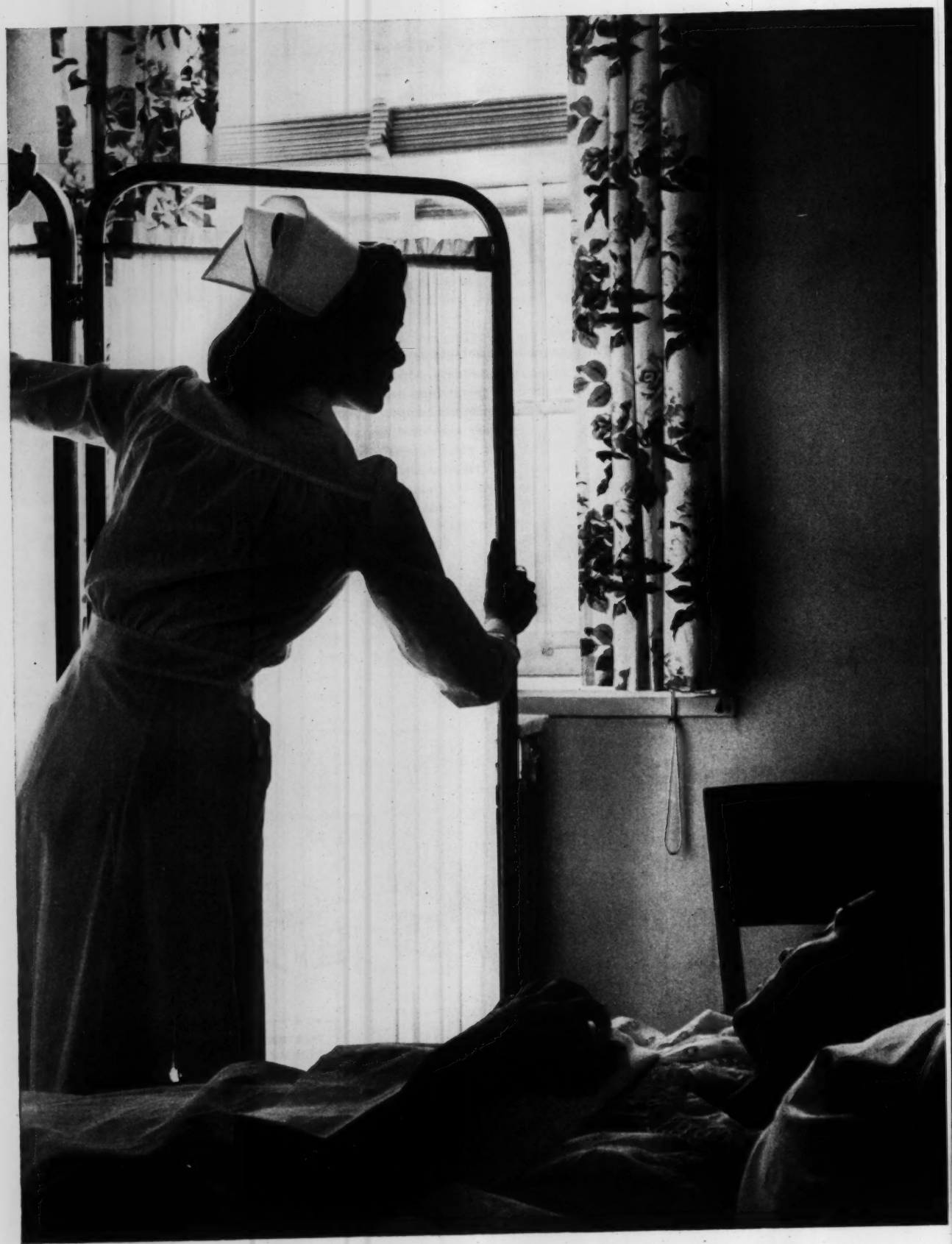
Name_____

Title (or occupation)_____

Company_____

Street_____

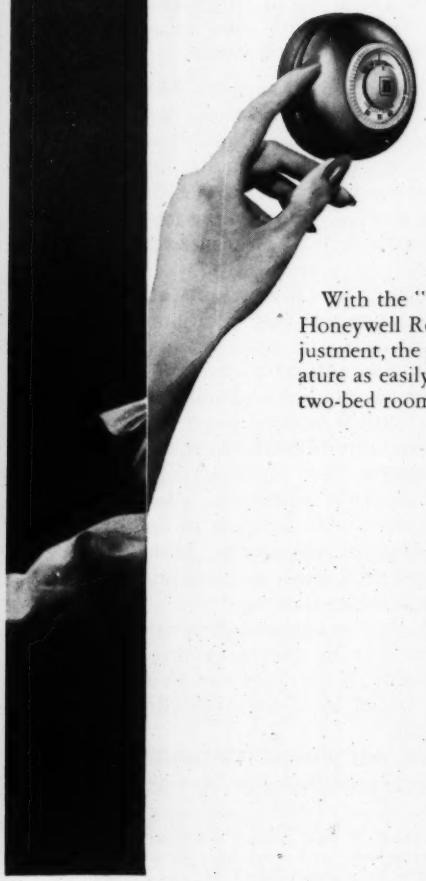
City_____ Zone____ State_____



HOSPITALS, J.A.H.A.

Save steps for busy nurses with Honeywell Bedside Temperature Control

Provide better therapy . . . more comfort for your patients



FREE your nurses from many of the time-consuming tasks of opening and closing windows, carrying blankets and refilling hot water bottles. Demands on valuable nursing time can be lessened when patients can make their own room temperature adjustments with a *Honeywell Bedside Temperature Control.*

With the "bedside" installation of the new Honeywell Round mounted for finger-tip adjustment, the patient can control room temperature as easily as reaching for a call button. In two-bed rooms the Honeywell Round can be mounted between the beds for easy access.

In addition, Bedside Temperature Control provides a saving in fuel costs by eliminating heating waste. It allows physicians and surgeons to "prescribe" exact room temperatures to help speed patient recovery.

Specify Honeywell Bedside Temperature Control for your new hospital or addition. Also available for your existing bedrooms at costs as low as $87.50 per room*. No tearing out of walls or redecorating is necessary. For more information, call your local Honeywell office now. Or, write Minneapolis-Honeywell, Dept. HO 11-82, 2727 4th Avenue South, Minneapolis 8, Minnesota.

**Average installed price for room with one radiator*

Honeywell

H HONEYWELL First in Controls

Cleaning cloth care

Do you have a formula for the treatment of dust cloths and floor cleaning cloths?

We do not have a specific formula for use in treating dust cloths. Perhaps the following information will be helpful in selecting one of the several good commercial products available for this purpose.

Dust cloths for use on furniture and equipment may be treated with a good grade of furniture polish, a light mineral oil, or refined kerosene. These cloths should not be used on marble, terrazzo, or window sills which are made of some substance other than wood or metal.

A neutral non-oily product should be used on the floor cleaning cloths. An oily, acidic, or alkaline cleaner may have a detrimental effect on your floors if they are of marble, terazzo, asphalt, or asphalt vinyl tile. It would be desirable to check the type of floor with your sanitary supply dealer or write to the manufacturer of your flooring material to determine the most desirable product for treating the cloths.

—JACK D. DILLMAN

Organization chart

We would like any suggestions you may have for establishing an organization chart for our hospital.

I would first suggest that you evaluate all the positions in your hospital by either a questionnaire to each employee or by a staff member doing the job. The important thing to obtain in the job relationship is who is responsible to whom.

Upon the completion of this evaluation, set each position down showing the job relationships. This will give a good picture of what exists at present and will provide you with a starting point for correcting any difficult organizational structure.

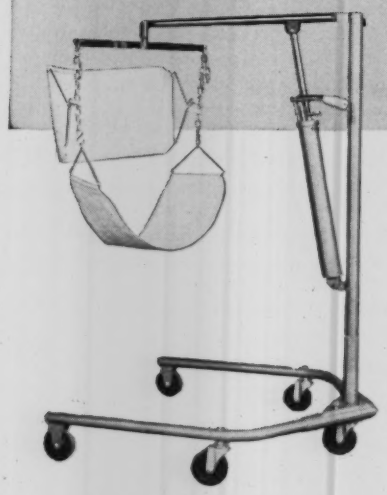
The chart could also show the various levels existing in the organization beginning with the board of trustees as level one, administrator, two, etc.

If your medical staff is salaried, they may be shown in line relationship, if not, they can be shown on a staff level with the administrator.

On all direct relationships a heavy unbroken line is suggested,

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

"patient lifting is no problem . . . NOW WE HAVE A PORTO-LIFT"



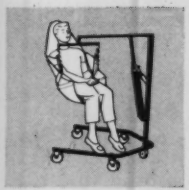
That's because PORTO-LIFT's simple, finger-tip hydraulic controls eliminate the old fashioned, physical strain of invalid moving.

It's so much easier on attendants . . . so safe, smooth and gentle for the patient.

For a time and labor-saver that will pay for itself in daily use, make it a point to look into PORTO-LIFT

PATIENT LIFTING • THERAPY • REHABILITATION

new Prone-Lift accessory



new interchangeable Head Rest accessory

SEE YOUR MEDICAL SUPPLY DEALER OR WRITE Dept. G 74

PORTO-LIFT MFG. CO.
Higgins Lake • Roscommon, Mich.

WESCODYNE® cleans as it disinfects

for less than two cents a gallon

FOR ALL AREAS

WESCODYNE is a completely new detergent-germicide that contains amazing "Tamed Iodine"®. Increases germicidal capacity three to four times and offers a much wider range of effectiveness than solutions containing chlorine, cresylics, phenolics or quaternaries.

WESCODYNE is also an excellent detergent as well as a powerful disinfectant. Provides fast cleaning action as it disinfects. A time and labor saver.

... all at a cost of less than 2¢ a gallon at use dilution!

WESCODYNE is nontoxic, nonstaining and nonirritating to the skin when used as directed. Further, it contains an exclusive "built-in" safety feature. In use, its amber color guarantees the presence of germicidal activity. When this color disappears, a fresh solution must be used. You're always sure of germicidal action!

WESCODYNE is recommended for almost any disinfecting procedure. Safe to use. Unaffected by hard or cold water. Leaves no "hospital smell." Send coupon for full information, including recommended surgical, nursing and hospital procedures.

LARGEST COMPANY OF ITS KIND IN THE WORLD

WEST DISINFECTING Company

WEST DISINFECTING COMPANY, 42-16 West Street, Long Island City 1, N. Y.
Branches in principal cities • In Canada: 5621-23 Casgrain Ave., Montreal

☐ Please send full information on Wescodyne.
☐ Please have a West representative telephone for an appointment.

Name.....

Position.....

Mail this coupon with your letterhead to Dept. 39

for any advisory or professional relationships, use a broken line. This broken line will show the relationship of the medical staff to the director of nurses, and perhaps the board. —JACK W. OWEN

Control of narcotics

What procedure would you suggest for handling narcotics in the emergency department? What type of drugs should be stocked?

You are probably aware of the new "Suggested Regulations for Handling Narcotics in Hospitals" as prepared by the American Society of Hospital Pharmacists with the cooperation of the Bureau of Narcotics of the Treasury Department. (Copies are available from the ASHP, 2215 Constitution Ave., NW, Washington 7, D.C.) These new suggested procedures cover nearly all aspects of narcotic control in hospitals. I suspect that this same outline could be applied to control of narcotics in the emergency department. I cannot see any objection to using the exact form as suggested for use within the hospital, and handling the narcotics in like manner in the emergency department. I am now speaking of narcotics which would be prepared and administered while the patient was in the emergency department of the hospital.

If the patient were to have additional narcotic medication on discharge from the emergency department, a prescription should be written and taken to the hospital pharmacy or to a nearby local retail pharmacy. This procedure would be identical to prescribing other medications in the emergency department. Prescriptions to be taken home by the patient should be written out in the usual manner and then filled by the hospital pharmacist or by the neighborhood pharmacist.

As to the type of drugs which should be stocked in the emergency department, this is a matter of local concern depending entirely upon the nature of work generally encountered in a specific emergency department.

Appropriate systems should be developed so that drugs which have been consumed during one eight-hour period will be replaced and available for emergencies which may arise during other periods of the day or night. This is particularly true of such medication as ampoules and other injectible medication. For small ampoules, for example, some hospitals employ an envelope system. In such cases, once the medication is used the empty envelope is returned to the pharmacy and replaced with new medication. This has an obvious advantage over anything that might resemble an ampoule box in that there is some assurance of replacement.

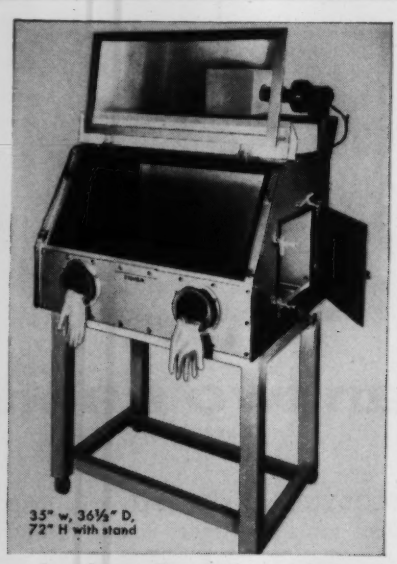
One procedure in handling drugs in the emergency department which deserves close scrutiny, is that of sending improperly labeled medication home with patients who have been treated. There are many obvious inherent dangers in this practice and it certainly should not be tolerated.

Many emergency departments of hospitals are now becoming known as poison control centers. Within the near future, articles on this subject will appear in this Journal, which would be of interest to you. —JOSEPH A. ODDIS

FISHER

ISOLATOR/LAB

a complete laboratory
in less than 7 sq. ft.
for hazardous and purity-sensitive operations

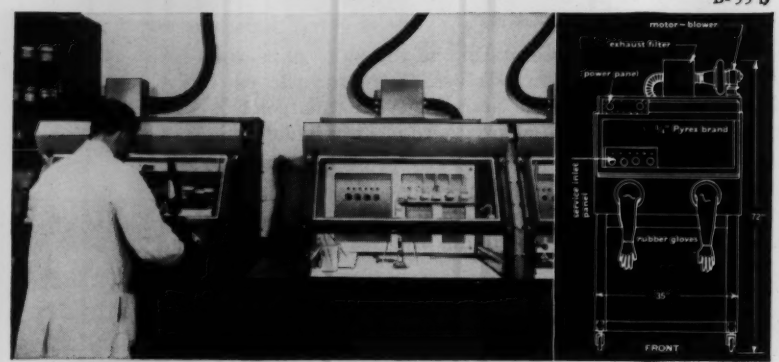


The Fisher Isolator/Lab is a compact, moderately-priced, self-contained laboratory within a laboratory. It has its own services, air supply and exhaust system.

The basic Isolator/Lab provides you with an isolating unit with scores of uses including: handling of toxic chemicals; bacteriological, radiological and metallurgical procedures; sterile pharmaceutical dispensing and packaging; allergy studies; etc. Whatever the use, the operator is at all times protected against hazardous materials and the material itself is protected against contamination.

And—as your needs grow, a wide variety of accessories may be added.

B-55 b



FOR "TELL ALL" BULLETIN
Write for 8-page bulletin which fully outlines this versatile instrument.

131 Fisher Building
Pittsburgh 19, Pa.

FISHER SCIENTIFIC
America's Largest Manufacturer-Distributor of Laboratory Appliances & Reagent Chemicals

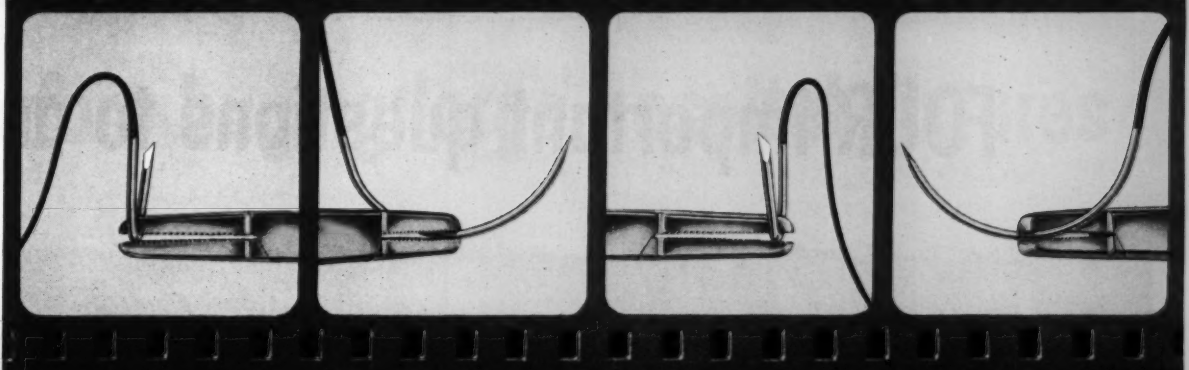
IN THE U.S.A.
Boston, Buffalo, Charleston, W.Va., Chicago, Cleveland, Detroit, New York, Philadelphia, Pittsburgh, St. Louis, Washington

IN CANADA
Edmonton, Montreal, Toronto

New point design gives unprecedented **sharpness**

DEKNATEL 'K' NEEDLE

Patent Pending



Starts as a Cutting . . . continues as a Taper Point . . . Combines advantages of both types.

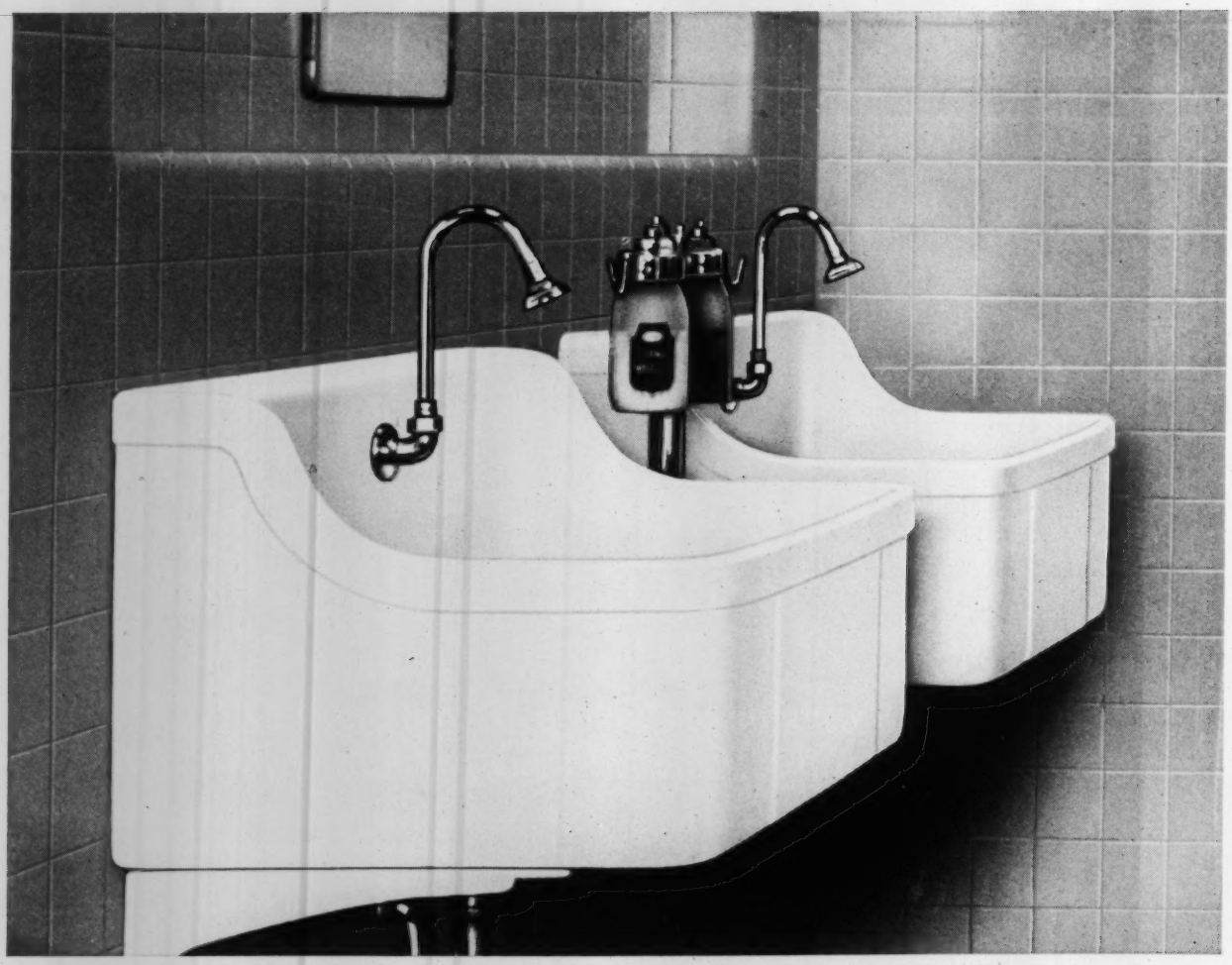
- All virtues of the Reverse Cutting Edge – none of its disadvantages.
- Greater precision of needle control.
- Less bending – or none.
- Permits use of finer needles.
- No enlargement of hole.
- Better pickup.
- Unsurpassed finish.

For samples, write:

DEKNATEL 96-20 222 STREET, QUEENS VILLAGE 29, N.Y.

CRA

FOUR important questions to ask



Crane "Mayo" Scrub-up Sink of Duraclay was designed in collaboration with doctors and hospital authorities at Mayo Clinic. Permits scrubbing up to the shoulder without touching unsterile parts of fixtures. Sink shown is installed in latest St. Mary's Hospital addition.

NE The Preferred Plumbing

before buying large hospital fixtures

1. Do they resist thermal shock? In 1939, Crane developed Duraclay—an all-ceramic material—for use in large fixtures subjected to sudden, extreme temperature changes (thermal shock). Duraclay easily withstands scalding heat one minute and icy cold the next—without cracking or crazing.

2. Are they specially made for hospital use? Duraclay fixtures have been specially designed for hospital use with the aid of doctors and hospital experts.

3. Are they easy to clean? Duraclay has a heavy vitreous glazed surface with all the easy-to-clean characteristics of the finest china dinnerware.

4. Do they resist staining and marking? Duraclay's hard glazed surface resists staining, pitting, or corroding from medicines and acids. Foreign deposits left on the surface of Duraclay can readily be cleaned, hours later, without any impairment to its gleaming white surface.

Why not test Duraclay's ability to take hard knocks right in your own hospital? Just ask your architect to include Crane Duraclay in your new or modernization plans. It's the surest way to get the most for your money in large hospital fixtures.

CRANE CO. 836 S. Michigan Avenue, Chicago 5

VALVES · FITTINGS · PIPE · PLUMBING · KITCHENS · HEATING · AIR CONDITIONING

St. Mary's Hospital, serving the Mayo Clinic, Rochester, Minnesota. Crane Duraclay fixtures were selected for the two additions to original building (center). First Duraclay installation was in 1939 addition (at right). New Duraclay installation went in addition just completed (at left). Contractors and Architects for the new addition were—General Contractor: McCarthy Bros., St. Louis, Mo.; Plumbing and Heating Contractor: W. J. Hankee Co., St. Paul, Minn.; Architects: Maguolo & Quick, St. Louis, Mo., and R. V. McCann, Minneapolis, Minn.

When surgery, fever and other debilitating conditions increase the patient's requirements for B complex plus C, Berocca-C provides a balanced comprehensive formula in a stable injectable form READY FOR IMMEDIATE USE.

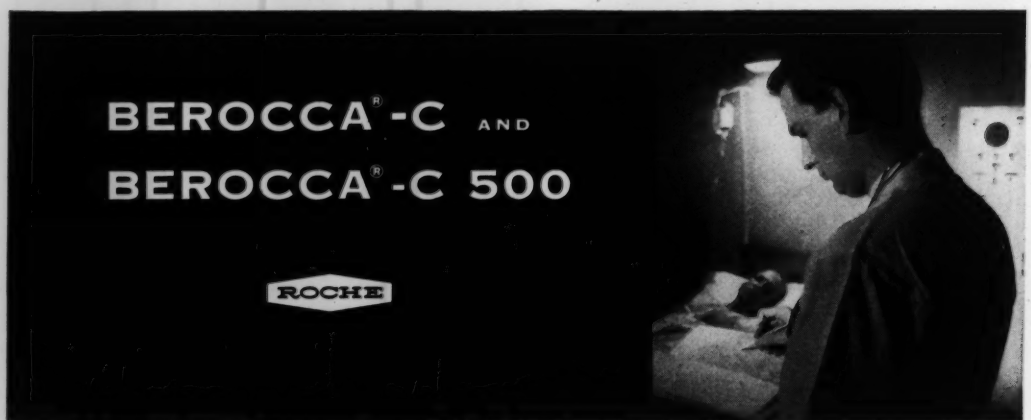
Berocca-C is time saving, for IT MAY BE ADDED TO INFUSION FLUIDS, or given by intramuscular or slow intravenous injection; it comes in labor-saving "color-break" ampuls; and IT IS ECONOMICAL.

Supplied: Berocca-C, 2-cc ampuls, 20-cc vials.
Berocca-C 500, duplex ampul packages, boxes of 50.

Each 2-cc ampul of Berocca-C contains thiamine HCl 10 mg, riboflavin 10 mg, niacinamide 80 mg, pyridoxine HCl 20 mg, d-panthenol 20 mg, d-biotin 0.2 mg and ascorbic acid 100 mg. When higher amounts of vitamin C are desired, use the Berocca-C 500 duplex package containing a 2-cc ampul of Berocca-C plus an additional 2-cc ampul of vitamin C injectable 400 mg.

ROCHE LABORATORIES

DIVISION OF HOFFMANN-LA ROCHE INC • NUTLEY 10 • N. J.



HOSPITALS
JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

editorial notes

—take a letter

Poor communications are the root of many administrative shortcomings and good communications are the heart of administrative triumphs. The written word seems to be the biggest communication barrier to many administrators. One needn't write so well as Shakespeare to be a good administrator but one needn't be at the other end of the scale.

A good letter or memorandum should get to the point quickly, without frills, in the simplest possible language. This is not merely a plea for brevity or simplicity. It is a plea to be as brief and as simple as one can be and still transmit the author's thoughts.

There are occasions when a long sentence is better than a short one—and all of the syllable and word counting formulae, a la Flesch—won't alter such occasions. There are occasions when a short word cannot be substituted for a long one. If you want to describe a word like "madam", only one word will do it—palindromic.

When a sentence must be long, it should be long. When the word has to be long, it should be long. Substitutions of inferior style or an inferior word is intellectual snobbery. Where there is a choice, the short sentence is to be employed, the simple word used.

There is no excuse to take 120 words to do a job which can be done in 12. We have a precise example at hand. The Association's library received a letter with a 119-word count. When the verbiage was scraped away, this is what the letter said: "Please send me material on a supply catalogue for the purchasing department." Count: 12 words. Even if you add the two politeness words "Thank You", there were 105 unnecessary words in the original.

As Pascal noted, it is harder to write a short letter than a long one. But writing reflects the man. It is a skill fundamental for an administrator. He must master it.

—the official insigne

All of us are familiar with the distinctive insigne of the Association—the shield quartered by a cross and bearing elements linking the device to health, to the United States (the eagle) and to Canada (the maple leaves) and the scroll with the Latin motto "Nisi Dominus Frustra." The motto is variously translated, usually as "Without God we can do nothing." Some older Bibles label Psalm 127 "Nisi Dominus" and the first verse begins: "Except the Lord build the house, they labour in vain that build it".

Thus our insigne provides beauty and a constant reminder of the religious background of hospital service to the sick and injured.

The insigne, as used for the last three decades, does lack one thing —specific identification as the seal of the American Hospital Association, for nowhere does our Association's name appear on the device. The need for such identification is evidenced by the certificate of accreditation given by the Joint Commission on Accreditation of Hospitals. The certificate bears the seals of each of the five supporting organizations. Only that of the American Hospital Association lacks pinpoint identification.

It seems obvious that when the insigne is used by the Association and in certain other cases, such as the accreditation certificate, the Association's name should appear on the seal. As a matter of fact, this is exactly what was intended when the emblem was adopted officially in 1927. The 1927 action provided that when the seal was used by the Association, the scroll should bear the words "American Hospital Association". When the seal was used by other organizations, the motto "Nisi Dominus Frustra" should be substituted on the scroll. In practice, the Latin phrase has appeared for both Association and non-Association use.

To drop the motto now, in conformity with the 1927 action, would be to lose a phrase of deep significance to the Association and to its membership. Because of the widespread use of the device, such a change would also create much confusion and cost as would correction of the heraldic errors which have been called to our attention from time to time.

Some action, however, was necessary because the seal as now used by the Association is not in accordance with the 1927 vote. The Board of Trustees has, therefore, approved a change in the insigne, when used by the Association and in certain special cases. The Board voted to encirle the core device with the legend "American Hospital Association. Founded 1898." The insigne as previously used becomes an integral part of the symbol and thus the emblems now in use by hospitals, auxiliaries, hospital associations, etc., need not be changed. The publications of the Association will, hereafter, bear the new seal, pictured below with the old one.

OLD SEAL

NEW SEAL

bedrails: up or down?

Based on a study by the Council on Insurance of the California Hospital Association, the author examines some factors affecting the incidence of out-of-bed patient accidents. He also discusses recommendations for the use of bedrails which resulted from this study.

ONE OF THE oldest stories in hospital lore is that of the student nurse who, on returning to her floor after a lecture on the importance of charting only what she observed, found a patient who had rolled out of bed onto the floor. The nurse, remembering her lecture, promptly entered on her chart, "Patient out of bed without permission."

With the increased number of geriatric patients in our general hospitals, as well as the impact of the early ambulation program, more and more patients are "out of bed without permission". Many of these patients are fully conscious and are trying to reach an elusive bedside table or switch. The greater number of them, however, are in a semiconscious state and are not fully aware of what they are doing. A surprising number do not even realize that they are in a hospital at the time of the incident.

LOSS OF CONFIDENCE

Fortunately, most of these patients are not physically injured. Any person who has the experience of rolling out of a hospital bed, however, must suffer some mental anguish and, at the very least, the loss of confidence in the hospital.

The Council on Insurance of the California Hospital Association has been particularly concerned with this problem over the past several years. There have been nearly 8000 out-of-bed incidents reported to the council since the inception of the program on Jan. 1, 1954. This is 40 per cent of all of the incidents reported. A very careful statistical analysis was made to see if these incidents followed a pattern which would point toward a solution. The results were most interesting. Important figures are as follows:

1. 75 per cent of all the patients involved were 50 years of age or older.

2. 11 per cent of such incidents happened between 9 p.m. and 11 p.m.; 20 per cent between 11 p.m. and 1 a.m.; and 23 per cent between 1 a.m. and 4 a.m., or a total of 54 per cent in the seven-hour period between 9 p.m. and 4 a.m.

3. 60 per cent of the cases were medical; 35 per cent surgical; and 5 per cent maternity.

4. 60 per cent were male.

5. 70 per cent had some type of sedation or narcotics within the previous 12 hours.

The typical case is, therefore, a medical case, with sedation, over 70 years of age, diagnosis—transurethral resection, cerebrovascular accident, or a cardiac condition.

Many solutions have been suggested and rejected. Obviously, 24 hours of special duty nurses would be helpful but in most cases impossible. Nets over the beds might involve the fire authorities. The suggestion of a net under the bed was held to be too impractical.

PATIENTS GO OVER RAILS

The answer always came back to the use of bedrails. But here we were faced with the fact that many of the patients go over the rails: out of the 7919 out-of-bed incidents reported, 4893 involved patients who had gone over the rails or over the foot of the bed. (This proportion is probably unusually high in California for reasons that will be explained.) The question is then raised as to whether or not the use of rails does not expose the patient to greater danger due to the fact that he may fall from a greater height. The figures prove conclusively that such is not the case.

	1954-56 Incidents	Claims paid	(No liability litigated cases)
Out of bed—			
over rails	**4,893**	**$ 3,000 (4)**	**6**
Out of bed—			
no rails	**2,926**	**29,000 (13)**	**2**

The amount paid out on claims is not necessarily the total answer as experience shows that it is much easier to defend or settle a case when the rails are up than when they are down. The patient's attitude toward the hospital is more friendly when he feels that the hospital has made an effort to protect him. The judge and jury are also impressed by this effort.

A review of the incident reports themselves, however, indicates that the injuries are much less serious and much less frequent when rails are in place. A further study has indicated the reason why the "no rail" cases are more serious than those in which a rail was in place. In the "no rail" case the patient often makes a free fall to the floor with very little chance of grabbing anything other than the bed clothes. On the other hand it was found that patients going over the top of full length rails were not dropping or falling from the top of the rail, but rather hanging on to the rail (even under the influence of heavy sedation) and sliding or climbing over the top and down to the floor.

DEFECTIVE BEDRAILS

In a few instances defective rails have been either improperly installed or not properly raised. As a result the rails have collapsed under the weight of the patient with rather serious consequences.

James E. Ludlam serves as legal counsel for the California Hospital Association. He is a member of the law firm of Musick, Peeler and Garrett.

This article is also being published in the November issue of *The American Journal of Nursing*.

circumstances in which siderails should routinely be required

1. All patients under sedation.
2. All patients in labor.
3. All patients with impaired vision.
4. All patients who are in shock or unconscious.
5. All patients with an admitting diagnosis of, "Under the influence of intoxicating liquors or narcotics."
6. All elderly patients in a confused or in a known senile condition.
7. All patients with toxic illness accompanied by marked elevated temperature.
8. All patients postoperatively for as long as necessary as determined by the patient's condition and the type of surgery.
9. On order of the attending physician. In general the nurse or special nurse should exercise judgment in the application of bedrails for circumstances other than those covered above. If the nurse believes the bedrails are essential but the physician does not, or vice versa, the physician should write appropriate orders in the chart. Nurses notes should also indicate when siderails are in place and when they are removed.

by JAMES E. LUDLAM

Another problem faced by hospitals is fixing responsibility for ordering bedrails. If ordering rails to protect the patient is the responsibility of the attending staff then the hospital can possibly avoid full responsibility for an injury resulting to a patient from failure to order rails. On the other hand, experience shows that relying solely upon the orders of the physician was not entirely satisfactory. This required frequent contacts with the physicians for special instructions and resulted in a wide variety of standing orders and general confusion.

Since the proper care of the patient must always be the first concern of both the hospital and the physician, the element of legal liability should not be the controlling element in any important decision concerning the welfare of the patient.

RAILS PERMANENTLY ATTACHED

Based upon its experience with this problem, the Council on Insurance of the California Hospital Association has recommended that:

1. Bedrails be permanently attached to every bed in the hospital as rapidly as possible. This recommendation is made for the following reasons:

(a) Experience shows that the nursing service will be more inclined to utilize the rails when they are readily available rather than stored in a closet at the end of a hall. It is no easy trick to install a cumbersome rail in the dark without disturbing the patient.

(b) The patient's attitude toward the permanent rail is better. He accepts the rail as a routine matter rather than an affront to his dignity, which may be the case if the nurse must make a major production of installing the rails.

(c) In multiple-bed rooms no distinction is made between patients. This can be particularly effective if similar types of cases are hospitalized in the same room so all are treated the same.

2. That hospitals, in collaboration with the medical staff, establish general standing orders for the use of bedrails. An example of such an order, which has been tested by experience as being effective and well accepted, is shown in the figure above.

The nursing department may not depart from the standing order without a written order of the attending physician accompanied by a signed release from the patient. It goes without saying that such a routine places an additional burden upon the nursing staff. They must respond promptly to the calls of the patient and must service additional nocturnal trips to the bathroom.

REDUCTION OF PATIENT ACCIDENTS

As a result of a series of institutes held throughout the state of California, sponsored by the Council on Insurance, the above program is being implemented. This is the reason for the high proportion of "over the rail" incidents, and, we also believe, the reason the number and seriousness of patient injuries is being reduced.

Where economically feasible, the electric alternate height bed with half rails appears to be of great advantage in solving this problem. No mass figures are yet available, but one hospital with 100 per cent installation found that over a period of two years, with an average daily occupancy of 120 inpatients, it had 110 out-of-bed incidents, of which 97 were classified as out of bed over the rails, and 13 out of bed—no rails. None of the incidents produced any fractures or serious injuries. The only injuries reported were friction burns and minor lacerations. Due to this limited study it is difficult to say that this type of bed and rail is the final answer. The indication is that the bedrails are acting as reminders or restraints and the patients that persist in getting out of bed are not receiving as serious injuries as compared with those in conventional height beds. Preliminary studies are being made on the use of the half rail on the conventional height bed.

Bedrails are far from the entire answer as there are many patients that need additional restraints. This again is a joint problem of the nursing service and the medical staff. However, regardless of the attitude of the medical staff on the subject of restraints, the nursing staff is going to make the decision—rails up—rails down. It is up to administration to establish the ground rules and furnish effective equipment. ■

SITUATED in the quiet suburban community of Neuilly on the Seine River, the 160-bed American Hospital of Paris is an imposing structure to the visitor from the moment he turns off Boulevard Victor Hugo and proceeds up the hospital drive.

THE beautiful grounds are visible from the hospital's lounge.

MODERN nurses home, completed in 1952, with its colorful living quarters and recreational facilities has proved helpful in enlisting the services of 136 nurses and technicians from the United States and 12 other countries. Many hospital personnel, however, live off the hospital campus. . .

the American

MANY OF THE greatest challenges to effective management of hospitals can be attributed to the organization of the hospital, its location, wide seasonal fluctuation in occupancy, type of patient served, and securement of professional personnel.

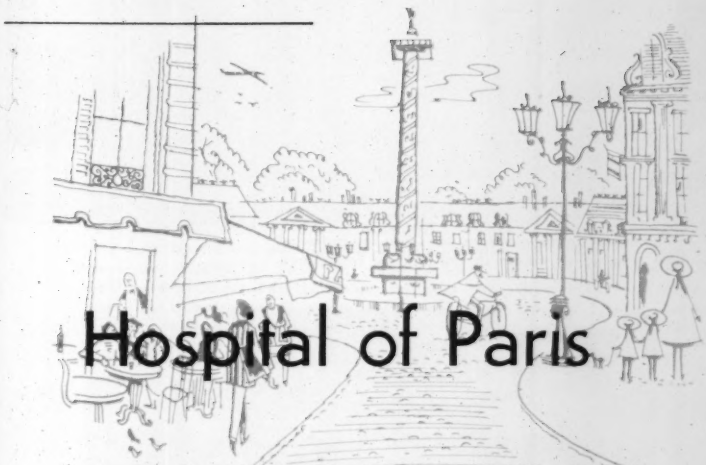
Although each hospital may be faced with one or more of these problems, hospitals abroad, leprosariums, prison hospitals and other unique installations are usually presented these challenges in a greater degree.

In the case of the American Hospital of Paris* at Neuilly-sur-Seine, France, it is the development and organization of the hospital that claim this prerogative.

When Americans started coming to Paris in increasing numbers at the beginning of the century, the need

*The cooperation of Hugh S. Fullerton, executive governor and administrator, and Otto Gresser, assistant administrator and business manager, made this pictorial presentation possible.

. . . and use the bicycle for transportation to work.



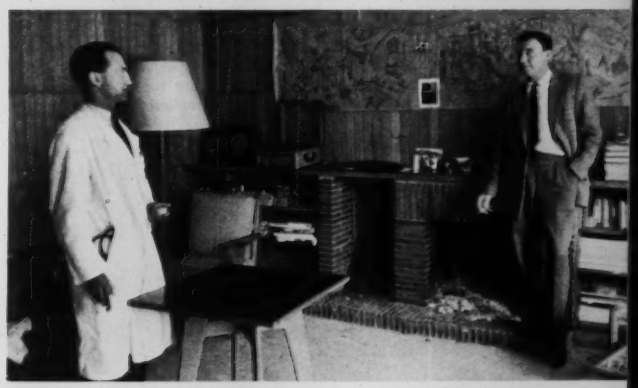
Hospital of Paris

was felt for a hospital where they would be treated according to American methods and by an English-speaking staff. In 1906 the American Hospital of Paris was incorporated under French Law and two years later the site for the hospital was purchased in Neuilly-sur-Seine, a suburb one mile west of Paris.

In 1913 the hospital was granted a federal charter by Act of the United States Congress. In 1918 the French Government accorded it official recognition as a public benefit.

When the first patient was admitted to this non-profit, general hospital 47 years ago, the American Hospital of Paris had 10 private rooms and 10 ward beds. Today the hospital has 160 beds, 50 of them temporarily used by the U. S. Armed Services in France. Featured at the hospital are modern, well equipped departments of x-ray, roentgentherapy, electrotherapy, pathology, physical therapy, out-patient service and laboratory analysis.

LIVING-IN facilities have been provided, too, for doctors, interns and their families. The residence is five years old.



BUILT in 1952, the residence (above) features oak paneled common room, where house officers can chat informally between assignments or use for playing chess in off hours (below).

(Continued)

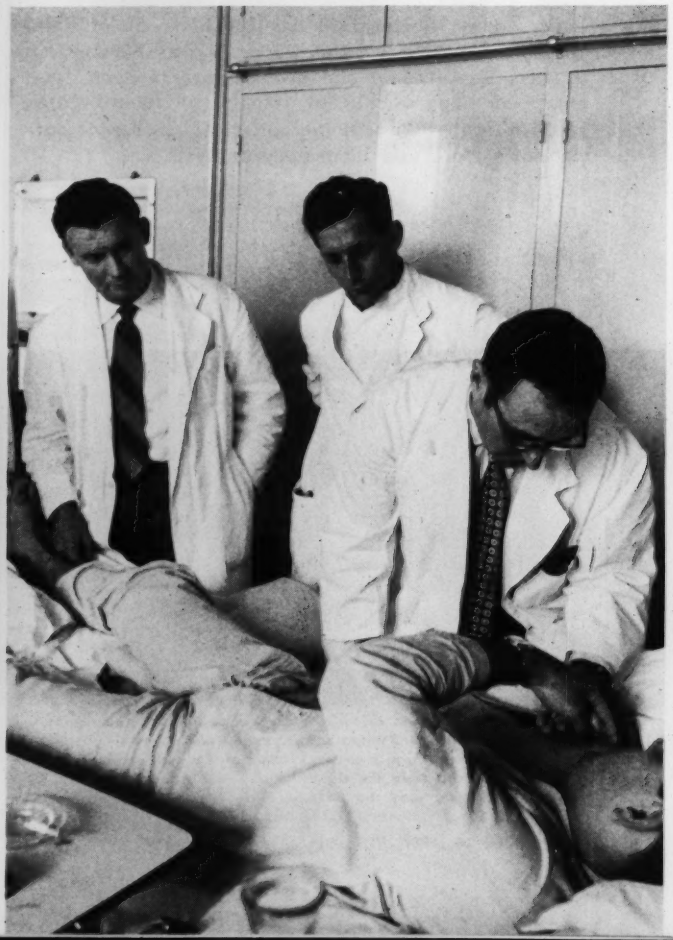
Executive Governor and Administrator Hugh S. Fullerton participates in all meetings of the 20-member board of governors as does Otto Gresser, assistant administrator and business manager. The board meets monthly. B. S. Carter (third from the right) is the 1957 board president. Only American citizens may be members of this administrative body.

The actual day-to-day operation of the hospital is supervised by a six-member management team, including (l. to r.) Mr. Fullerton; Dr. L. S. Lipstitch, chief of the medical staff; Elizabeth Comte, directress of general services; Mr. Gresser; Elizabeth O'Neill, superintendent of nursing, and Ernest Luginbuhl, assistant to the business manager.

ONE of the recent topics of discussion at management group meetings was the execution of disaster drills, including patient evacuation and training of nurses in fire-fighting techniques.

THE hospital has an attending medical staff of 67 doctors, with Dr. L. S. Lipsitch (left) as chief of staff. There is a consulting staff of 70 members and a courtesy staff comprised of prominent French physicians and surgeons at the American Hospital.

A 15-member medical board, headed by an American, is responsible for the medical and surgical standards of the hospital. Dr. N. C. Rogers (head of table) presides at the monthly meetings of the board.

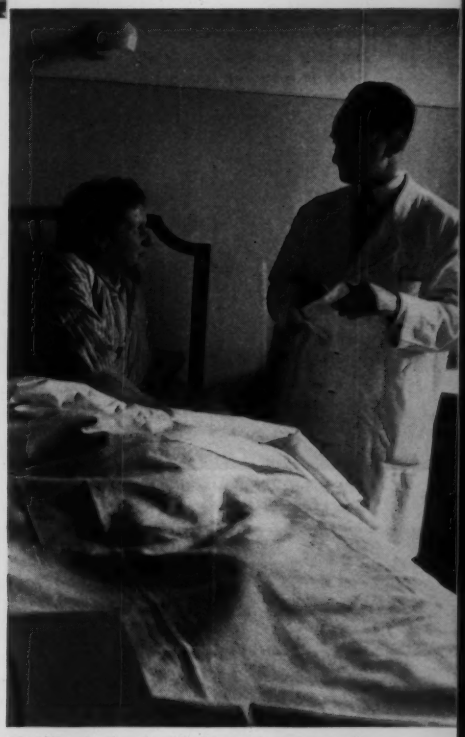


IN addition to conferences with medical staff members and house officers . . . the chief of staff holds bedside consultation with the resident staff as part of its residency training.

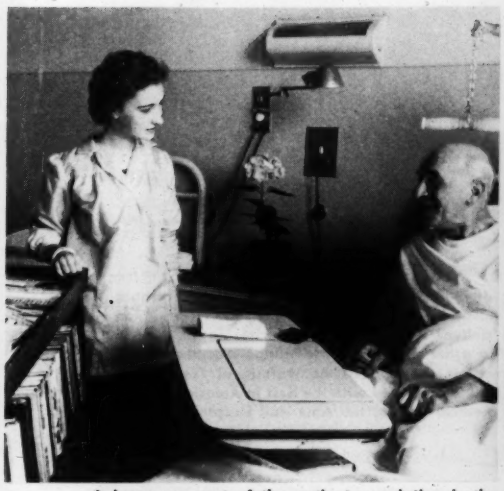
(Continued)

THE only Blue Cross participating hospital outside the continental United States, the American Hospital of Paris last year rendered care to approximately 325 patients holding Blue Cross hospitalization insurance. Mr. Gresser (seated at desk) holds a Blue Cross conference with the chief accountant, medical record librarian and the assistant to the business manager to discuss the filing and completion of Blue Cross forms.

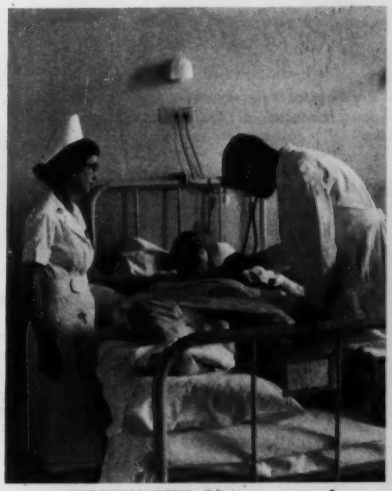
TO INSURE patients the best in patient care, Miss O'Neill (foot of table) reports to head nurses new ways to improve patient service on the floors.



MANY of the hospital's patients use the obstetrical services. Last year 900 babies were born at the hospital in suburban Paris.



A large segment of the patient population is the American tourist. A member of the hospital's women's auxiliary committee brings books and magazines to an American tourist from New York.



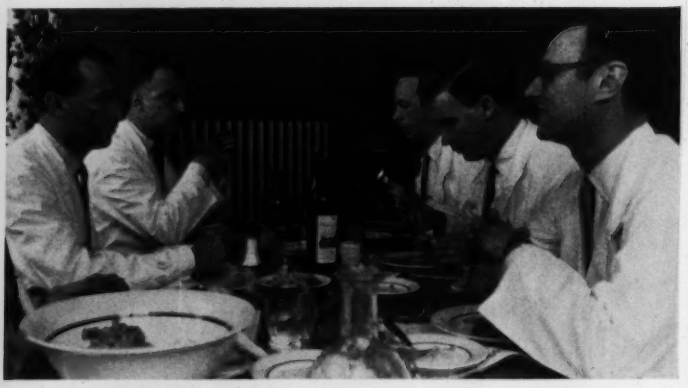
APPROXIMATELY 30 per cent of the total hospital beds are set aside for members of the U. S. Armed Forces and their dependents.

THE Army section includes a dispensary, where Col. George V. Potter, chief medical officer, watches Dr. Anthony Grasset apply a bandage to a United States Army patient.

(Conclusion)

ON THE ground floor of the hospital all food for Armed Service patients is prepared and served according to Army rules and regulations.

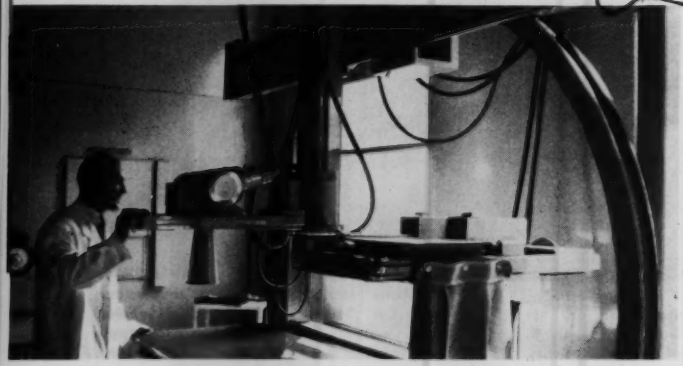
FOOD for all other patients is prepared and served under the supervision of Marie-Jeanne Mermillod, chief dietitian (with clipboard in hand).



Doctors are served family style, with wine a standard table appointment.

PROCUREMENT of heavy equipment from the United States is an expensive and long-term project, but the American Hospital of Paris has many new large pieces of equipment, including a tomograph for diognostic x-ray . . .

. . . and a 500 Ma. unit for diagnostic roentgenological examinations.



FLORAL deliveries are received at the main entrance of the hospital, where at least one concierge is on duty to deliver flowers, assist a visitor in securing a taxi, or to usher a guest to the lounge-reception room. These symbols characterize the warmth of French hospitality that is combined with the best in American hospital and medical care at the American Hospital of Paris.

reimbursement system in retrospect—

10-year look at uniform cost accounting

by FRASER D. MOONEY, M.D., and CARL M. METZGER

In the June 1954 issue of this Journal, the authors collaborated in preparing an article that described the uniform cost accounting system used in western New York by Blue Cross and cooperating hospitals in determining reimbursement rates. So much interest was created by the article that the authors have brought the story up to date in this 10-year evaluation of the program.

TRADITIONALLY, THE best way to start a friendly argument has been to discuss either politics or religion. The matter of equitable reimbursement for services provided by hospitals under Blue Cross contracts, however, is often a third contender for this dubious distinction among hospital people.

In the western New York section the aggravation of this problem has been minimized through joint effort of representatives from the member hospitals and Blue Cross. The reimbursement system developed by these representatives has been tested and revised for 10 years, and the following material is an appraisal of the system in the light of this experience.

JOINT COMMITTEE ESTABLISHED

Eleven years ago, having tried every known basis for reimbursement arrangements and finding them all wanting in some way, a joint committee was established consisting of three members of the Western New York Hospital Council and three members from the board of directors of Blue Cross. The committee was charged with establishing specific objectives and then determining methods which would as nearly as possible satisfy those objectives.

The following objectives were set up by the joint committee:

1. Assure hospitals of adequate reimbursement for services rendered without sacrificing the quality of those services.
2. Develop a system whereby Blue Cross charges to the public could be stabilized, or at least tied directly to economic trends.
3. Develop a method of reimbursement which would create an interdependence between the hospital and Blue Cross.

A method that seemed to satisfy these objectives was developed and termed a "uniform cost accounting program".

This program aimed at applying the same yardstick to determine the costs of all hospitals and providing the basis for compensating them accordingly within specified limits. The term "uniform cost accounting" is somewhat of a misnomer since people tend to think of this as relating to "pure" costs. ("Pure" costs here mean only current expenditures incident to providing the patient's services that are clearly definable and identifiable with a particular patient's case.) With any substantial portion of a hospital's case load producing revenue at pure costs, the solvency of the institution admittedly would be in jeopardy unless the balance of the paying patient case load produced income substantially in excess of cost to offset collection losses and for free and part pay care, etc.

Actually, the committee developed a cost formula which was uniformly applied by a staff of full-time cost accountants making quarterly audits of all member hospitals. Over and above the pure costs which are determined, additional allowances are made for depreciation of buildings and equipment, interest on indebtedness, medical and nursing education and for a proportionate share of losses incurred for free or part pay outpatient services. In addition it was agreed that the real endowment of secular institutions consists largely of the difference between the value of the services performed by nuns and the actual normal salaries and subsistence allowances which they receive. In these institutions, the program allows for a cost allocation for nuns' salaries at approximately the "going rates" for similar services in hospitals of similar size.

The program also recognizes the fact that during continuing inflationary periods actual costs for a given period can only be determined after they have been incurred. Retroactive adjustments, therefore, must be made to supplement the current "on account payments" which Blue Cross makes to the hospital following discharge of the case.

The foregoing condensation of

Fraser D. Mooney, M.D., is director, Buffalo (N.Y.) General Hospital. Carl M. Metzger is president, Hospital Service Corporation of Western New York, Buffalo.

the objectives and procedures of the uniform cost accounting program is presented as a basis for understanding the evaluation of the project which follows. This evaluation refers mainly to the success with which the predetermined goals have been reached. Each point is elaborated, however, in an attempt to show that the real worth of the program is even more far reaching than was anticipated.

table 1—Comparison of increase in hospital costs per patient day between all U.S. hospitals* and member hospitals of the Western New York Plan.

	Year		Increase	
	1948	1955	Amount	Per cent
All hospitals in continental United States*	$14.06	$24.15	$10.09	71.8
Member hospitals of Western New York Plan	$12.02	$19.11	$ 7.09	59.0

*From Guide Issue of HOSPITALS, J.A.H.A., Aug. 1, 1956. For all short-term, general and special hospitals.

ADEQUATE REIMBURSEMENT

On an average, approximately 60 per cent of the operating revenue of the 34 hospitals concerned is received through Blue Cross patients. The Blue Cross subscriber's contract is a relatively comprehensive one. It was drafted to provide benefits for the customary charges for services necessary to the patients' welfare. The usual luxury services are not included.

In most hospitals the established charges of the hospital for specific services do not bear any uniform and direct relationship to the costs of providing those services. There is generally no consistent pattern of charges as a percentage of costs. Hospitals have hesitated to make frequent changes in their schedule of charges and as a result of the inflationary spiral the past several years, they have often found themselves in a position of making charges inadequate to support current costs. The inevitable result has been annual deficits.

Under the uniform cost audit approach the actual "pure" cost of providing services is determined for each quarter of the year, usually within 45 days from the close of the quarter. The agreement between hospitals in western New York and Blue Cross provides that the preceding year's determined cost shall be the basis for current "on account" payments by Blue Cross, subject to retroactive adjustments to cover the actual costs incurred at the time the service was provided. Added to this "pure" cost is the plus amount for the items previously enumerated which are not Blue Cross benefits.

The hospital derives additional income from the Blue Cross patient at rates in excess of actual cost through the collection of differences for private room service, telephone, radio, television, guest trays and similar items. When a major portion of a patient's bill is paid by Blue Cross the patient can afford to be a little more extravagant than necessary on luxuries nonessential to his care. It is not unusual therefore in a substantial number of cases that the hospital's total income from Blue Cross and the patient combined is in excess of the amount which would have been received had the hospital rendered minimum services, billed at its scheduled rates, and collected the full amount of these charges.

There is ample evidence that these hospitals—being assured of income from 60 per cent of their case load at the equivalent of cost plus—have repeatedly added to or expanded their services for the benefit of the public. The only restraint placed on the individual institution in expanding present service or initiating new services is the provision that although each institution shall be paid its own cost, such payment by Blue Cross shall not exceed greater than 10 per cent over the average costs of all of the institutions participating in the program. This provides an incentive for hospitals rendering either limited kinds of service, or substandard service (which tends to reduce their costs below the average of all of the hospitals in the community) to bring those standards and the number of services up to normal.

This matter of "floor and ceiling" limits is one of the very few points on which there is not complete agreement between the member hospitals and Blue Cross. One of the university affiliated teaching hospitals shows a cost which is almost consistently higher than the ceiling and another hospital is also frequently in such a position. These hospitals naturally resent accepting payment of an amount lower than their cost when some hospitals with a cost lower than the floor (10 per cent lower than average cost of all hospitals) realize a "profit", so to speak. Actually, there is complete agreement of thinking among the parties that this constitutes an inequity, but no one has yet produced a satisfactory solution.

BLUE CROSS RATES

During the years that the program has been in effect, the consolidated cost reports which have been developed very clearly forecast trends in hospital costs. The frequency of the audits permits accurate plotting on a graph and the range can be predicted within acceptable limits. Using this information as a guide, coupled with the usual statistical data employed in the calculation of subscription rates, Blue Cross has been able to establish subscription charges adequate to meet cost fluctuations over a period ranging from 30 to 36 months and do so within 5 per cent of actual experience.

The fear that tying Blue Cross rates to hospital cost variables would create a hazardous financial situation for Blue Cross has never been substantiated. As a matter of fact, ability to announce subscription rate increases, which are an accurate reflection of scientifically determined hospital costs, has made those rate increases far more palatable to the public.

Since the program is jointly operated between hospitals and Blue Cross and the expense of the audits is equally shared, a closer relationship and understanding has developed between the two groups. This arrangement has made seminars for accounting personnel from the hospitals both possible and desirable. These meetings deal not only with routine hospital accounting problems, but with the proper methods of report preparation to hospital management, welfare departments, and other regulatory bodies. They are conducive to a more orderly and effective interchange of ideas for systems and accounting efficiency. Because of the coordination of the project by Blue Cross and the necessary frequent personal contacts involved, a rapport has developed between the hospital staff and the Blue Cross staff which would be difficult, if not impossible, to achieve otherwise.

But more important than any of the foregoing has been the result of an exchange of accurate cost information by which hospital administrators could evaluate their own operation in relation to either other hospitals of comparable size, or all other institutions in the area.

All hospital administrators have faced the extremely difficult task of trying to limit or control the rate at which their patient day costs have been increasing during the inflationary period of the last 10 years. The unusually low record of patient cost increases in western New York is due almost entirely to the use by administrators of uniform cost reports developed under this system. The tabulation and comparison of increases in western New York and the continental United States are shown in Table 1, page 54.

PUBLIC ASSISTANCE CASES

In the past the task of a group of hospitals negotiating adequate rates of reimbursements for public assistance cases has been in most areas a frustrating experience. When it was possible to negotiate a uniform flat rate of payment, the variation in the actual costs of individual hospitals—due to the extent of service, efficiency of the plant, etc.—generally influenced the regulatory body responsible for these payments to establish rates which were somewhat below the arithmetic average of the costs reported by the hospitals. The net result was that while a few, and usually the smaller hospitals, received a reasonably adequate compensation, the larger hospitals handling a majority of the cases received an amount insufficient to cover the actual out-of-pocket expense for these cases. It naturally followed that charges to the individually paying patients had to be set sufficiently high to assure a gross income great enough to offset the deficits on the welfare cases.

Shortly after the uniform cost accounting program was established the officials in two of the counties in western New York recognized the validity of the uniformly determined cost approach and its value to the community as a whole. They agreed, as a first step, to pay the determined cost of the second preceding quarter for the current quarter's welfare cases. While this did not represent the actual cost of services to welfare patients during the time the expense was actually incurred, it was nevertheless a substantial increase over the rates previously paid.

The New York State Welfare Department also became interested in the development of a more equitable and uniform program of hospital reimbursement for welfare cases. (The state reimburses the county for one-half of this expenditure within certain limits.) Following the general principles of our formula and applying what appeared to them to be proper modifications for their particular requirements, the state, two years ago, outlined a suggested basis for reimbursement to hospitals by the various counties. There was an understanding that if such a formula was applied the state would reimburse the county for a full 50 per cent of the county's expenditures.

This was the culmination of gradual increases in payments made over a period of years, during which the uniform cost findings became the basis for negotiation with the county welfare departments. Not all of the increase year by year (shown in Table 2, at left) is attributable to the uniform cost accounting program, of course. There has also been recognition of increased costs of operation. Prior to the uniform cost accounting program, however, that recognition was not only

(Continued on page 120)

table 2—Comparison of welfare rates paid in Erie County before and after such rates were negotiated on basis of state formula.

Year	Average per diem cost (ward)**	Welfare rates paid in Erie County hospitals*		
		Rates negotiated	Amount under ward costs	Per cent of ward patients concerned
1947	$ 9.48	$ 5.50	—$3.98	58 per cent
1948	10.82	6.50	— 4.32	60.1
1949	11.64	8.50	— 3.14	73
1950	12.15	10.00	— 2.15	82.3
1951	13.10	10.50	— 2.60	80.2
1952	14.47	11.75	— 2.72	81.2
		(State formula applied in negotiating welfare rates)		
1953	15.11	12.92	— 2.19	85.5
1954	16.30	14.73	— 1.57	90.4
1955	16.91	16.17	— .74	95.6
1956	18.64	17.27	— 1.37	92.7

*Not all counties in western New York participated fully in the recommended state formula. Erie County, with the greatest density of population in western New York, does. It was previously close to the bottom of the scale in payments made for welfare cases. Erie County was used in the chart for these reasons.

**Per diem costs for 1947-1952 computed for all member hospitals; costs for 1953-1956 computed for only Erie County member hospitals.

BASIC courses in theory are shared by both surgical and obstetrical technicians at St. Joseph Hospital, Memphis, Tenn. Practical training for these technicians, however, is limited to the department in which each will serve after graduation.

because a Jack-of-all-trades may be master of none, this hospital tried

a new twist in technician training

by SISTER M. NORA, R.N.

The author describes a program of technician training that provides clinical experience in only one department of the hospital. She also discusses the reasons for and results of this specific type of preparation for nonprofessional personnel.

A COMPARATIVELY new group of workers has appeared on the hospital scene in the last few years to alleviate the shortage of professional nursing personnel. Called surgical technical aides, or often simply "technicians", they are being trained to assist surgeons and obstetricians. Many busy supervisors will agree that the value of such workers is now beyond the stage of controversy. Developing the kind of training program which will prove most satisfactory to all concerned, however, is still a problem.

Most programs provide a concentration of theory in a five-week period, followed by practice under supervision. The usual plan is to rotate the technician through surgery, obstetrics, and in some instances, central supply.

Since the greater part of such experience is in surgery, the student often prefers to remain in surgery after graduation. This means that the clinical skills gained in obstetrics and central supply are of little use to the students, and certainly of no use to the departments concerned. When transfers are requested, almost as much orientation is required as if no clinical experience had been offered.

Sister M. Nora, R.N., M.Ed., is obstetrical supervisor, St. Joseph Hospital, Memphis, Tenn.

SHARING THEORY DESIRABLE

It would seem more practical to assign technicians to the department of their choice from the first day of their preparation. Sharing of theory in some areas is desirable, of course, but sharing all clinical experiences is inadvisable. Such sharing does not seem to produce more proficient or flexible workers, nor does it channel the student to the department in which she will achieve the greatest satisfaction.

St. Joseph Hospital has put a "specific field" theory of technician training into practice for five years. Certain basic courses are shared by all technicians. All are instructed in orientation to the hospital, ethics, professional etiquette, anatomy, bacteriology, and principles of sterilization. (At present technicians in central supply receive only practical training, on-the-job.) The surgical technician does not receive special training in obstetrics at all. The obstetrical technician does not need the extensive terminology associated with names of operations, nor a review of positioning and draping which surgical technicians need.

In obstetrical training there is, however, a need for skill in nursing arts, to provide comfort to patients in labor, while the surgical technician rarely sees the patient on the wards where such skills are necessary. Furthermore, in those rare intervals when the delivery rooms are not busy, it is an advantage to use a competent person in the postpartum section to assist with baths, perineal care, treatments, making formulas, or to help in the nursery. (See chart, page 57, for complete outline of technician training program at St. Joseph Hospital.)

LACK OF TEXTBOOKS

One difficulty encountered in preparing technicians is the lack of textbooks for this group. Those written for practical nurses are helpful in the study of anatomy,

but bacteriology is inadequately covered. The nursing procedures described are not too helpful in the kind of work technicians are required to perform. It would seem that a well illustrated text could be used by all groups as a basic course, including anatomy, bacteriology, personal hygiene, hospital ethics, principles of sterilization and operating room technique. In addition to the basic text, obstetrical technicians would need a book on obstetrics, such as is written for student nurses, emphasizing the first stage of labor by the use of many illustrations.

The results of this program have been satisfactory at St. Joseph Hospital. Only one request for a transfer from one department to another has occurred in five years. It appears that it is more practical to train subprofessional workers for a specific field and help them to become efficient in that field, rather than to teach a number of techniques in a short space of time.

The flexibility of transfer of technicians (if requested) has not suffered either, for, while it is not encouraged, still it is possible. The extensive experience in assisting with caesarean sections provides an excellent background for assisting with any kind of abdominal surgery if the technician wishes to transfer from obstetrics. Of course further orientation is required. The surgical technician transferring to obstetrics is required to attend the course in obstetrics as soon as it is offered. Technicians transferring from central supply, having had no theory, would find it necessary to take the entire course in the department of their choice. ■

technician training at St. Joseph Hospital

Both surgical and obstetrical technicians share theory in the following classes:

Hospital ethics, etiquette, personal hygiene	20 hours
Anatomy	10 hours
Bacteriology	10 hours
Principles of sterilization	20 hours
Total hours of shared theory	60 hours

Obstetrical technicians then receive additional clinical and classroom work in:

Obstetrics	20 hours
Nursing arts	20 hours
Delivery room techniques	10 hours
Total special hours	50 hours

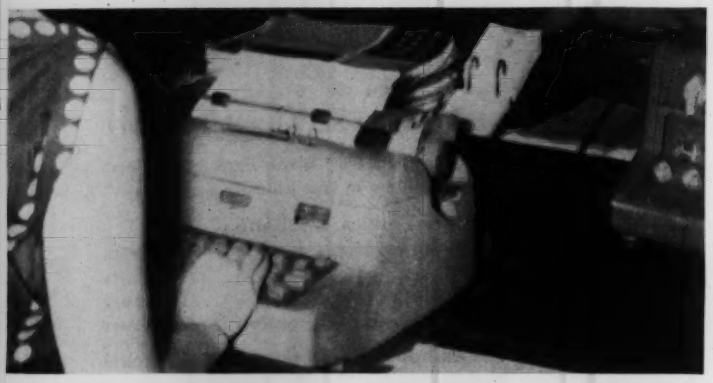
Surgical technicians then go on to study surgical clinical techniques for a year together with approximately 18 hours of additional theory. Work includes:

- Fire hazards peculiar to surgery
- Anesthetics
- Legal responsibility
- Positioning and draping of patients
- Terminology
- Sutures, needles, instruments
- Care of specimens
- Duties in workroom, sterilizing room, operating room
- Care of equipment

mechanizing the

ELECTRIC TYPEWRITERS CAN SAVE TIME AND MONEY

by HELEN B. LINCOLN and JOSEPH SHERBER



DAILY REPORT — STENOGRAPHIC DIVISION

DATE 1/30/55

INCOMING DICTATION

Received Today	Summaries	Operations
Medicine Private and SP	25	
Pavilion	4	
Surgery Private and SP	40	
I		
II	14	
III	4	
Orth	9	
Plastic		
Neuro-Surgery		
ENT	4	
Eye	8	
Urol		
Ped		
Women's Clinic	83	
Gen. Surg. Op. Notes		13
10th Floor		16
11th Floor		2
Urol.		4
Neuro-Surgery		5
ENT and Eye		4
Total Received Today	191	44

EDIPHONE PRODUCTION - RECORD DEPARTMENT

Date 1/30/55 Name M.D.

STANDARD LINE COUNT--

Cartons over 2 -- 1 line each
Summary heading to Chief Complaint -- 3 lines
Operative heading to Procedure -- 5 lines
Envelopes -- 2 lines each

History No.	Service	(Check) Summary	(Check) Op.	Lines Typed
415276	Ob.		✓	39
741054	Surg.		✓	75
583202	"		✓	62
744069	"		✓	67
179905	"		✓	61
435939	Ob.		✓	50
653430	Surg.		✓	59
740826	Ob.		✓	60
306239	Surg.		✓	18
377211	Surg.		✓	22
738008	Surg.		✓	18
741244	"		✓	18

SUMMARIES _____ Total Production Time 6 hr. 50 min. (Minus Non-production Time)

OPERATIONS 12 Total Lines 549

fig. 1

ANYONE in charge of medical stenographers or medical transcribers is familiar with the difficulty in procuring well trained personnel in this field. Anyone in charge of this work in a hospital also knows the increased demands upon the medical records department for transcripts necessary in processing insurance claims.

The authors describe the methods by which The New York Hospital studied the effect of electric typewriters on the output of their central transcription pool. They also discuss the results of this study in the areas of production, personnel, and cost.

At The New York Hospital, summaries on patients discharged from our 1207 inpatient beds and all operative procedures are transcribed in the central transcription pool in the medical record department. In 1955 when the work load was mounting and the supply of trained personnel decreasing, we decided to explore the field of "automation" and see what electric typewriters could do to improve this situation. Our procedure of recording transcribers' output on simple production sheets (Fig. 1, at left) gave us a ready-made basis for such a study.

DAILY LINE COUNT

A line count is kept daily by each transcriber showing (1) service, summaries, and/or operative notes transcribed; (2) total lines transcribed; and (3) hours for the day minus nonproductive time such as clerical work, straight typing, and time spent in clinics or absences. (A cardboard ruler marked for lines is placed on the transcribed copy, and by subtracting lines for paragraphs, the line count is quickly obtained.) Operative note headings are counted as five lines, and summary headings as three lines. Each additional carbon after the first two is valued at one line, and an envelope is assigned a value of two lines.

Analysis of the daily sheets of each transcriber on a weekly sheet gives the basic production picture (Fig. 2, page 60). This weekly sheet summarizes total discharges requiring summaries (secured

(Continued on page 60)

Helen B. Lincoln, C.R.L., is chief medical record librarian, and Joseph Sherber is administrative assistant, The New York Hospital, New York City.

TELETYPE EQUIPMENT CAN SAVE TIME AND LIVES

by ELTON A. REESE

Alamosa (Colo.) Community Hospital uses teletype equipment to receive specialists' reports from a larger hospital 150 miles away. The author explains some of the advantages resulting from this arrangement and discusses the cost of the teletype service.

FOR 10 YEARS, x-ray films and pathological specimens from Alamosa Community Hospital were sent for interpretation to specialists 150 miles away at St. Francis Hospital in Colorado Springs. Three days elapsed from the time a specimen or x-ray was mailed to the radiologist or pathologist until the report reached the Alamosa hospital. It was often necessary to use long distance telephone calls to obtain reports, especially in cases involving operative cancer or difficult fracture patients.

About a year ago a new method of reporting these specimens and x-rays was developed. Both St. Francis Hospital and Alamosa Community Hospital were supplied with teletype machines. Today, the x-rays and pathological specimens are sent to the specialists at St. Francis Hospital by special delivery and usually arrive over night. The following morning by approximately 9 or 10 a.m. the pathologist and radiologist have their reports available. These reports are sent back to the Alamosa Community Hospital by teletype. Even though isolated, the Alamosa hospital can obtain x-ray and lab reports in a few hours. In no case does it take more than 12 hours.

WRITTEN REPORTS ALSO SENT

Electrocardiograms are also sent to St. Francis Hospital and are interpreted by the staff of cardiologists. An ECG done on any given day is reported the following morning by 10 a.m. Later a written report in more detail is presented to the doctor for further study.

The cost of this procedure is not prohibitive. The teletype machine at the Alamosa hospital was installed and the cost is based as follows:

Rental per month	$10.00
Unattended station feature (machine turns on without operator being present.)	3.00
Plus tax	1.36
Total monthly cost	$14.36

Any messages eminating from the Alamosa hospital are billed to that hospital at the usual per minute rate. Naturally, this is not found to be exhorbitant since the bulk of the messages are originated from St. Francis Hospital by the pathologist and radiologist. The machine at St. Francis Hospital is charged for in the same manner. There the bill is larger because the messages being sent are longer.

The specialists involved, however, find that the cost of the teletype barely exceeds the cost of long distance phone calls previously used for emergency reporting. This additional cost is offset by the knowledge that better service is provided for the patients of the Alamosa hospital. Doctors of the Alamosa Community Hospital staff are appreciative of the fact that they can obtain an expert opinion on any x-ray, pathological specimen or ECG within a matter of hours.

TREATMENT INITIATED EARLY

It cannot be determined if any lives have been saved as a result of this program within the past years, but in all instances treatment could be initiated earlier, thereby saving time and money for the patient. Furthermore, patients could usually be treated on a local level since it was not necessary to send them to a larger hospital for special tests.

The teletype can be used to contact any other business or industry that has the teletype available. These groups are listed in a general teletype book. For instance, the administrator can make hotel reservations in another city by means of teletype. Much of the ordering can also be done if the house with which the hospital does business has the service of a teletype. Not only is the teletype worthwhile for x-ray, lab, and ECG work, but it can also be used in the business phase of hospital administration. ■

Elton A. Reese is superintendent, Alamosa (Colo.) Community Hospital.

(Continued from page 58)

from the daily census), total operative notes required (secured from the daily operating room schedules), the incoming dictation on summaries and operative notes, and the line count tally of each transcriber.

From the production sheets for 1954 and a 17-week period in 1955, it was possible to get the average line count for summaries and operative notes. This was determined by dividing the total lines transcribers typing summaries or operative notes produced by the total number of summaries or operative notes. The result showed an average of 48.9 lines for summaries and 37.6 lines for operative notes.

An analysis of the number of weekly discharges, deaths, and operative procedures gave us an average weekly production load of 428 summaries and 268 operative notes for the period. These figures multiplied by the average lines for summaries and operative notes gave us a total of 31,006 anticipated lines of production per week. We learned, from our production sheets, that the transcribers averaged approximately 31 hours per week of actual transcription out of a total work week of 36½ hours. The remaining time, exclusive of lunch and rest periods, was spent on clerical work and other typing. From a sample of 5173 hours spent on transcription a total of 274,072 lines were produced. This meant an average of 53 lines per hour per operator.

With this data we were ready to make a limited trial of electric typewriters. A New York company loaned the hospital one electric typewriter for a five-week period. During this time two operators participated in the study. Each operator spent one week learning the operation of the machine before her production was measured. One person was a long-term employee, the other was a new employee.

A study of the production reports of these two participants indicated that their production increased after one day of practice and that this increase continued through the one-week learning period and into the trial period. Each person made approximately the same per cent increase with the electric typewriter (see below).

	PREVIOUS AVERAGE PRODUCTION	AVERAGE PRODUCTION WITH ELECTRIC TYPEWRITER	PER CENT INCREASE
Typist 1	**62.7 lines per hour**	**84.2 lines per hour**	**34.26 per cent**
Typist 2	**45.1 lines per hour**	**59.2 lines per hour**	**31.26 per cent**

Prior to the start of the test both participants were asked to continue work in their normal manner. After the test both said they had not worked any harder than before and, in fact, had experienced less fatigue. By using an electric typewriter, the typist is able to shift the typewriter carriage, space, set tabs and margins without having to lift her hands from the keyboard. In addition, two ounces of pressure on a key will produce a typed letter as compared to two pounds pressure required on a manual typewriter.

On the basis of our findings we estimated the installation of electric typewriters in the typing pool at The New York Hospital would increase our production by about 33 per cent. With an average production of 53 lines per hour, an increase of 33 per cent would raise the average hourly production to 71 lines per hour. For The New York Hospital this meant that with electric typewriters, 14 full-time employees plus 28 weeks of vacation relief would be needed to meet the production demand as compared to 19 full-time employees plus 38 weeks of vacation relief which had been our experience with manual typewriters.

fig. 2

REPORT TRANSCRIBING UNIT—RECORD DEPARTMENT

Week Ending 1/30/55

Name	Transcribing	Typing	Other	Non-productive*	Total**	Lines Trans.	Lines Typed	Net Total	Required Lines	Remarks	Sums.	Ops.
R.A.	26	—	—	—	26	1700	—	1700	1500	Part Mon. Gyn	25	
L.B.	34	—	—	—	34	1665	—	1665	2000	Gyn	33	
M.D.	26	—	Consult 1½	B&½	34	1662	—	1662	2000	Gyn.		52
new E.D.	46½	7½	—	—	34	1001	500	1501	2000	Surg	23	
new D.H.	34	—	—	—	34	1455	—	1455	2000	Med Surg	25	
M.S.	—	—	—	B34	34	—	—	—	—	—	—	—
B.J.	34	—	—	—	34	1385	—	1385	2000	Med	16	
E.L.	31	—	Consult 3	—	34	2019	—	2019	2000	Med Surg	33	
A.M.	33	—	Consult 1	—	34	1729	—	1729	2000	Surg		45
R.M.	33¾	¼	—	—	34	1618	37	1518	2000	Neuro Surg	17	
Y.N.	?	Teaching etc			Temp	606	—	606	Temp	Part Time		19
B.P.	?	Participating		B&½	34	1561	—	1561	2000	Med Surg	9	29
O.S.	31½	1½		B&½	34	2156	—	2156	2000	Part Med Surg	16	19
new P.W.	34	—	—	—	34	1427	—	1427	2000	Part Surg	20	
Unfilled	—	—	—	34	34		—	—	—	—	—	—
		73¾	5½	83½	468	19847		20384	27,500		217	164

Discharges for Summaries: 476 Operations for Notes: 278

Incoming Dictation: Summaries 369 Operative Notes 2367

*Code for Non-productive time:
A Equipment inspection or repair
B Ill or absence
C Late
D Other

**Work week: 1 hr. for lunch, 2 15 min. relief periods, every Saturday off.

COSTS AMORTIZED

Projecting basic personnel salaries, vacation relief, new equipment, installation of equipment, power, maintenance and repair, it was estimated that the costs of purchase and installation could be amortized during the first year with a substantial dollar saving. The purchase of electric typewriters was approved and machines were installed.

A transcribing pool presents a constantly changing picture as to work loads, variable work content, shifting emphasis, and changing personnel both in number and quality of background and training. It is, therefore, not possible to state and guarantee a definite dollar-and-cents saving. It is possible, however, to show an estimated range of increase in production due to ease of operation in the use of electric typewriters. Similar studies, where volume of work is expected from several typists, would probably demonstrate results comparable to those found in the experience of The New York Hospital.

The first eight weeks after installation, including a break-in period, showed an over-all increase of 22.8 per cent for the unit. In another 10 weeks we showed a 31.8 per cent increase with line count still going up. At the present time long service employees are maintaining an average line count of 71, 84, and 90 lines per hour. ■

POLLING PATIENTS AND PERSONNEL—part II

what factors affect patients' opinions of their nursing care?

by FAYE G. ABDELLAH and EUGENE LEVINE

Part I of this series of articles described how the Division of Nursing Resources of the Public Health Service and the American Hospital Association studied omissions in nursing care reported by patients and personnel in 60 short-term general, nonfederal hospitals. The most and least frequently reported omissions in care were described.

In this article the authors analyze omissions in care reported according to age, sex, marital status, and type of room accommodation of the patients who reported them. Parts III and IV of this series concern what hospital personnel think of patient care, and what hospitals can do to improve patient care, respectively.

ACCORDING TO a recent study,* the unhappiest patient in a hospital is a young unmarried female in a large adult ward (nonobstetrical). At the other extreme, the happiest patient is a married male over 60 years of age in a private or semiprivate room.

Table 1, page 62, shows how 8660 patients who participated in the study that produced these results were distributed according to age, sex, and marital status. The characteristics of the patients in the study compare very closely with patients in all short-term general, nonfederal hospitals in the United States.

The age of the patient—more than any other patient characteristic studied—seemed to make the most significant difference in the number of unfulfilled needs reported. Younger patients consistently reported more unfulfilled needs than older ones. Of the total group of 9000 patients, 33 per cent reported that all their needs were filled; only 24 per cent of the patients under 20 reported complete satisfaction with their care; while 40 per cent of the patients 60 and over said that they had all their needs met. (See Table 2, page 62.)

MALES MORE SATISFIED

When the sex of patients was studied, males seemed a little more satisfied than females. In the hospitals studied, 35 per cent of the males reported that all their needs were met. The number of women who were completely satisfied was 29.7 per cent, excluding obstetrical patients, who as a group, were as happy as males (Table 3, page 62).

Marital status also seemed to make a difference in the amount of unfulfilled needs that were reported. Among the single patients, nearly 28 per cent said that all their needs were met; while among the married patients, 34 per cent said that they were completely satisfied. In some age groups, however, single patients reported fewer omissions in care than married patients. This is seen in Table 2, where the percentage of people with fulfilled needs are shown by their age and marital status. The table shows that married patients between the ages of 20 and 29 seem to be more satisfied with their care than single patients in the same age group. On the other hand, the single patients from 30 to 39 were happier than the married patients in that age group.

The effect of different size room accommodations upon the patient's satisfaction could not be clearly determined from this study. Patients in large, open wards report slightly more unfulfilled needs than do patients in private or two-bed rooms—but the difference was not great enough to be of practical importance.

AGE GIVES CLUE

Because of the significant relationship between the number of omissions reported and age of the patient, an analysis was made of each unfulfilled need voluntarily reported by patients on the space provided on the check lists. The comments of two groups were compared—those under 40, and those 40 and over. Although older patients reported fewer unfulfilled needs than younger patients, many unfulfilled needs reported by them were similar, while others were quite different from those reported by the younger patients.

Following is a comparison of the concerns of the older and younger patient by three groupings of events: food, environment, and noise. The items were selected from the many comments that patients wrote on the check lists. As all patients did not contribute comments on their check lists, broad generalizations cannot be made from this analysis. However, many clues for the improvement of patient care are inherent in their remarks.

1. Comments about food—The older patient's concern with food was

Faye G. Abdellah is chief of the nursing education branch and Eugene Levine is chief of the statistical branch, Division of Nursing Resources, Department of Health, Education, and Welfare.

*Conducted by the Public Health Service and the American Hospital Association. See part one of this series, p. 44, HOSPITALS, J.A.H.A., Nov. 1, 1957.

table 1—Age, sex and marital status of 8660 patients in study of patient care, 1956.

Sex and marital status	Age							
	All ages	Under 20	20-29	30-39	40-49	50-59	60 and over	Unreported
Total, all patients	8660	715	1564	1435	1325	1385	1969	267
Male	3175	297	299	388	564	650	948	29
Single	635	270	123	46	53	57	81	5
Married	2082	3	165	314	447	502	637	14
Other*	458	24	11	28	64	91	230	10
Female	4980	401	1220	1010	704	666	908	71
Single	560	253	73	45	52	40	94	3
Married	3549	134	1121	873	550	462	349	60
Other*	871	14	26	92	102	164	465	8
Sex unreported	505	17	45	37	57	69	113	167

*Other includes widowed, divorced, separated and unreported.

table 2—Per cent of patients reporting no occurrences of omissions in nursing care, by age and marital status, study of patient care, 1956.

Marital status	All ages	Under 20	20-29	30-39	40-49	50-59	60 and over
Total, all marital status *	33.3	24.2	27.9	30.0	32.2	36.5	39.8
Single	27.6	21.9	19.1	30.0	26.9	39.2	46.8
Married	33.6	30.7	29.3	30.8	31.6	36.9	40.7

*Includes single, married, divorced, separated and unreported marital status.

table 3—Per cent of patients reporting no occurrences of omissions in nursing care, by sex and marital status, study of patient care, 1956.

Marital status	Both sexes	Male	Females nonobs.	Females obs.
Total, all marital status*	33.3	35.1	29.7	—
Single	27.6	29.7	23.1	—
Married	33.6	36.2	29.8	35.1

*Includes single, married, divorced, separated, and unreported marital status.

table 4—Average category scores for patients, by size of hospital, study of patient care, 1956.*

Category of events	Size of hospital by daily average patient census			
	All sizes	100-199	200-299	300-499
Number of hospitals in study	60	33	15	12
Average score, all events	**8.4**	**7.7**	**7.7**	**9.9**
Rest and relaxation	11.6	11.3	11.2	12.1
Dietary needs	10.1	10.0	9.0	11.4
Elimination	8.2	7.8	7.0	10.1
Personal hygiene and supportive care	5.3	4.6	4.5	7.0
Reaction to therapy	7.8	6.4	7.8	9.2
Contact with nurses	8.8	8.2	7.9	11.1

*A low score indicates a satisfactory situation, while a high score indicates a less satisfactory situation.

that there be variety in menus; that food be easily digestible; and that it be served attractively. He seemed to be more sensitive to coffee that had been brewed in a container that was not properly cleaned. His appetite was not as keen as the younger patient.

The younger person was concerned with not only a variety of food, but more of it, and food that was filling. The long span between supper and breakfast was a long time for him to wait for meals. He liked his food to be cooked properly, and he did not like it to be seasoned in a way that was not appetizing.

2. Concerns about hospital environment—The older patient was concerned with being confined to bed for lengthy periods of time. He was more sensitive to the cold and temperature changes than the younger patient. Time span seemed much longer to older people. For example one patient wrote on her check list that 20 minutes seemed like two or three hours. The older patient was concerned with the little things—the so-called niceties—having his kleenex at hand, having his venetian blinds drawn in a certain way. The older patient was concerned with more comfortable hospital equipment and often suggested redesigning bedpans.

The younger person seemed to be preoccupied with avoiding boredom. He was more active mentally and physically, and liked to have more people around him. He preferred not to be with older patients, even though he wanted companionship more than anything else. He wanted to talk and play his television set and radio. He was more critical of the services that were being provided. He liked to have things explained to him. He was not overly concerned with the room being cluttered, or in getting sleeping pills as was the older patient.

3. Concerns about noise—The things that were of concern to the older patient in the area of rest and relaxation were directed mainly at radios and television sets. The older patient wanted and desired more privacy than the younger patient. He was much more sensitive to environmental noises, such as noisy food trucks,

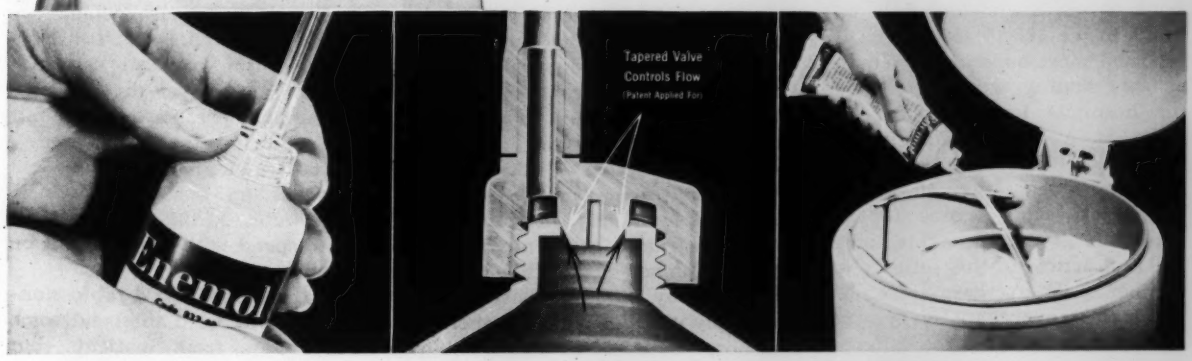
"Enemol makes giving enemas an easier chore"

It used to be that preparing and giving those routine enemas topped my list of "Most Unpleasant Nursing Chores." But, with Enemol — it's so much easier and faster that I don't mind it nearly as much.

The thing I like best about **Enemol*** is that there's no equipment to assemble or solutions to mix. Better yet, there's no messy equipment to clean up afterwards because you just throw the used container away. That means as much as 20 minutes saved — to spend doing something else.

Enemol ***is the only disposable enema*** I know of, with a shut-off valve you can easily open and close with a simple twist. You can even clear air from the tube before inserting. The tube, with its soft round top, is just stiff and long enough (6 inches) to insert easily without hurting the patient.

Having an enema is never pleasant, but Enemol makes it a lot less uncomfortable for the patient to take. That's because there are only 4½ ounces of fluid instead of the usual quart. And for routine enemas, this time-proven phosphate solution really does a better job than soap suds.



Enemol disposable Enema Unit

- *Saves nursing time*
- *Reduces expense*
- *Increases patient comfort*

*TM

Packed in easy-to-handle cases of 24; 4½ oz. units.

60th *fine pharmaceuticals for 60 years*

SINCE CUTTER 1897

CUTTER LABORATORIES

BERKELEY, CALIFORNIA

and other equipment used in the hospitals studied. He liked a limited number of visitors, and was annoyed by too many visitors—particularly visitors who smoked too much.

The younger patient viewed the interruptions in his visiting hours or treatments as a paramount concern. He wanted more visitors and was not concerned with too many visitors or the room being cluttered as was the older patient. He preferred to have his radio and television running and resented having the older patient or nurse telling him to shut it off. He liked to see more people than was allowed. He resented being awakened for temperature taking or for routine medications. He wanted to be treated more like a well individual.

EFFECT OF HOSPITAL SIZE

The 60 hospitals participating in the study were divided into three size groups—the first included hospitals from 100 to 199 daily average patient census; the second from 200 to 299 daily average census; and the third from 300 to 499. It was found that patients in the two smaller size groups reported the least number of omissions of nursing care—while patients in the 300 to 499 size group reported most omissions. (Whether this finding would hold true for hospitals in the country at large is a subject for further study.)

Table 4, page 62, shows the average category scores for the three size groups. As explained in the first article in this series (November 1 issue) these scores are obtained by averaging the percentage of occurrence of the different omissions in care in the category and weighing occurrences by the importance of the omissions in terms of patients' welfare.

Three categories of omissions in care stand out in setting apart the small from the large hospitals: (1) elimination, (2) personal hygiene and supportive care, and (3) contact with nurses. Although certain factors, like patient's age, sex, and marital status, were similar among hospitals in the three size groups, further study would need to be done to prove that it is sheer physical size that make patients complain more in larger hospitals, rather than other correlated factors.

MORE NURSING CARE

An analysis was made of the events specifically pertaining to the nurses' contact with patients to see if there was any significant difference in patient satisfaction in those hospitals employing a larger number of nonprofessional nursing personnel than professional. The events included in this category, for the most part, require a high level of professional nursing competency. Many of the patient's needs in this area affect the patient's emotional security and his acceptance of therapy. Many of the unfulfilled needs reported by patients very often stem from emotional insecurity and anxiety over being in the hospital. Examples of events included in this category are: "Nurse left me before I could ask questions"; "Nurse didn't seem interested in me"; "Nurse is always in a hurry"; and so forth.

When the volume of omissions in care was related to the daily average hours of nursing care provided it was found that in hospitals where a larger amount of nursing care was provided by professional nurses, the number of unfulfilled needs reported by patients was considerably less than in hospitals where a smaller amount of professional nursing care was provided. Total hours of nursing care available—professional plus nonprofessional—on the other hand, were not related to the number of unfulfilled needs reported by patients. There were as many unfulfilled needs reported in hospitals that had high and low *total* hours of nursing care but the same amounts of professional nursing care. Before a direct causal relationship between hours of professional nursing care and omissions reported is inferred, however, the presence of a third factor, like philosophy of the hospital towards patient care, needs to be ruled out as the real underlying causal factor.

KEY TO PATIENT SATISFACTION

Many benefits, of course, result when patients' needs are met to the fullest extent. Apart from the humanitarian standpoint, there are medical, economic and other advantages. When patient needs are fulfilled, there is a greater acceptance of therapy. This helps patients make a more rapid return to their communities and resume a productive life. It is within the realm of professional nursing to provide quality nursing care to insure that the greatest number of patient needs are met.

If quality nursing is so closely allied to professional nursing, and considering recent increases in the number of professional nurses in hospitals—why are there still so many patients' needs not being met? One barrier preventing the professional nurse from spending more time on patient-centered activities is the tremendous increase in treatments ordered for patients. The preparation and cleaning of equipment involved in these treatments takes her further away from the patient.

Also, nurse utilization studies conducted by the Division of Nursing Resources show that the average professional nurse spends only about 26 per cent of her time on activities with patients. About one-fourth of her time is spent on activities that are not "nursing" at all—such as housekeeping activities that could be done by maids, routine clerical activities that could be done by a clerk, and running errands off the unit that could be the responsibility of messengers. A professional nurse seldom has more than a few minutes during an eight-hour day to spend with each patient on the unit.

It is expected that a professional nurse will need to spend some time away from patients—but can't this time be reduced? Granted, she can do much during even such a brief contact with a patient, but it is the sustained, unhurried contact with the patient that gives her the opportunity to allay his fears and to provide him with the needed emotional security. Many of the 60 hospitals participating in the study have already taken specific steps to solve many of the problems highlighted in this article. The actions that they have taken will be presented in the final installment of this series. ■

In biopsy of the vertebral body

Correct placement of the biopsy trocar calls for careful checking of position. Each radiograph made to guide procedure must cover a wide range of tissue densities, offer unusual sharpness of detail.

You can count on Kodak Royal Blue Medical X-ray Film, fastest film available, to give you dependable results at greatly reduced exposure. In fact, experience shows that previously used MaS factors can generally be cut in half with final adjustments made by minor changes in kilovoltage.

In developing: To take full advantage of the greater speed of Royal Blue, it should be developed for 5 minutes at 68°F or the equivalent. For top performance use Kodak Liquid X-ray Developer and Replenisher or Kodak Rapid X-ray Developer.

Order from your Kodak x-ray dealer

EASTMAN KODAK COMPANY
***Medical Division*, Rochester 4, N.Y.**

Kodak
TRADE MARK

In recognition of the importance of the environmental health and safety concept to every hospital department, space ordinarily devoted to the Professional Practice and Laundry-Housekeeping sections of the Journal has been set aside for this special feature. The regular schedule for departmental articles will be resumed in the December 1 issue.—The Editors

environmental health and safety

four specialists explore four areas of concern in keeping the hospital safe for patients, personnel, and visitors

INTRODUCTION

by RICHARD G. BOND

"ENVIRONMENTAL HEALTH AND SAFETY" can be defined as the control of all those factors in the hospital's environment which exercise, or may exercise, a deleterious effect on the physical development, health, or well-being of patients, staff personnel, and the visiting public.

Environmental health and safety specialists are concerned with the physical structure of the hospital and its equipment as used in the care of the patient, other duties of the staff, and the accommodation of visitors. This concern is expressed from the earliest stages of planning, through review of design and performance specifications, and subsequently with all aspects of operation of the facility.

More specifically, environmental health and safety encompasses at least the following activities in the hospital: *

1. Sanitation and safety features of all aspects of food preparation and service in the hospital.

2. Water supply, including its safe distribution and protection against contamination; water conditioning, including distillation, softening, deionizing, and the relationship of these treatment methods to the problem of pyrogens.

3. Radiological safety as it relates to both radioisotopes and x-rays; the protection of patients, nurses, doctors, operating personnel, and visitors.

4. Collection, treatment and disposal of solid and liquid wastes, infectious or noninfectious, with special consideration for radioactive wastes.

5. Air conditioning, heating and ventilation, including air disinfection with its special problems of controlling biological contaminants.

6. Actual and potential exposures to toxic gases, vapors, and fumes; noise control; lighting, particularly as it relates to nursing and medical care; and the maintenance of housekeeping standards.

7. General safety for all personnel, encompassing disaster planning and fire safety programs.

8. Health and safety features of laundry operations, insect and rodent control, maintenance of swimming pools and hydrotherapy equipment; and sanitation and housekeeping problems which relate to research animal facilities.

Four problem areas have been selected for discussion in the articles that appear on the following pages. There is no particular significance to this selection; any of the other subjects just named might as well have been presented.

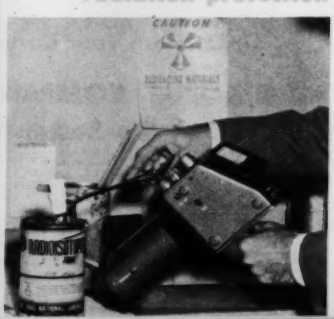
The authors compose a team who work daily in an operating program in the University Health Service at the University of Minnesota involving all of the components of environmental health and safety. This team represents a combination of several technical skills for the purpose of dealing with health and safety problems in the hospital environment. ■

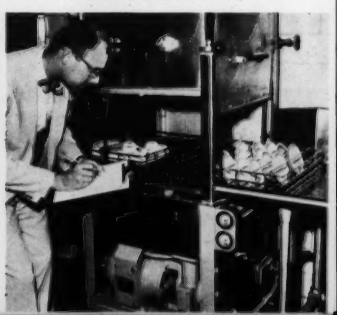
Material on this and the following pages is adapted from presentations by the authors at the 1957 Upper Midwest Hospital Conference in Minneapolis.

Richard G. Bond is an associate professor at the School of Public Health, and public health engineer and director, Division of Environmental Health and Safety, University Health Service, University of Minnesota.

*These groupings form the general outline for the University of Minnesota course in institutional sanitation, which for many years has been included in the curriculum for hospital administrators.

safety program · occupational hazards · radiation protection · food sanitation





Now available

BUFFERIN® 1000's

in a package especially designed for the modern hospital pharmacy

BUFFERIN—the better-tolerated antacid analgesic—is especially valuable for the treatment of arthritis and other conditions which require high-dosage, long-term salicylate therapy. BUFFERIN *contains no sodium*, thus is suitable for patients on salt-free diets.

Reprints of articles on the pharmacology and clinical use of BUFFERIN are available on request.

- **SAVES SHELF SPACE**
- **SAVES TIME IN DISPENSING**
- **ECONOMICAL**
- **IN AMBER SPACE-SAVER BOTTLES**

Each BUFFERIN tablet combines 5 grains of aspirin with the antacids aluminum glycinate and magnesium carbonate.

BRISTOL-MYERS COMPANY, 19 WEST 50 STREET, NEW YORK 20, N. Y.

wishing won't make it so—

a good safety record calls for action —AND MAYBE MONEY

by JOHN MORRIS

LEFT: University Hospitals safety committee is composed of heads of departments and led by the associate director of the hospital. Here the committee discusses the use of safety cans for dangerous liquids and safety goggles. Larger departments also have safety organizations. RIGHT: An important aspect of safety engineering is preventing the incorporation of safety hazards into construction. George S. Michaelsen (left), industrial health engineer, discusses such hazards with another member of University Hospitals safety staff.

Sustained and conscious effort in the direction of safety can be expected to bring about dramatic reductions in injuries and the cost of injuries, the author states. Other tangible and intangible benefits of a hospital safety program are listed, along with the mechanics of setting up such a program.

BEFORE A safety program can pay dividends, there must be some action. The administrator must participate—and he may have to spend some money. In the hospital I know best, for example, money is going into the improvement of certain doors which have proved to be hazardous. This project included reconstruction of one door so as to recess it away from the main corridor. Another troublesome pair of doors has been improved by inserting windows, so preventing collisions caused by people who could not see what was coming. Electric eye operation of some doors is under consideration.

Safety cans for flammable solvents—here is another deserving project recommended to administration by our safety committee, and one which is being accepted in various departments. Any sound investment in safety or fire protection has a direct benefit in the protection provided, and indirect benefits in good relationships with the staff and good public relations.

In our hospital, three administrative committees work out problems of fire, safety and disaster planning. Our safety committee is composed of department heads, and meetings are conducted by the associate director. The larger departments also have their own safety activities. The nursing services department has a model organization which draws members from various services and occupational levels; for example, it includes a supervisor from psychiatry, and aide from surgery and a head nurse from pediatrics, also an orderly, an aide and a licensed practical nurse from other areas.

Participation in a safety program should be kept largely within the hospital family. It is unwise to rely heavily on outside agencies in safety or fire protection matters either in inspection or in preplanning of new construction.

BENEFITS FROM PROGRAM

What benefits might we expect to receive from a going safety program? Our hospital's program produced some rather startling figures in our first year of con-

At the time this paper was prepared, John Morris was an instructor at the School of Public Health and safety supervisor of University Health Service, University of Minnesota. He is presently safety coordinator at the University of Illinois.

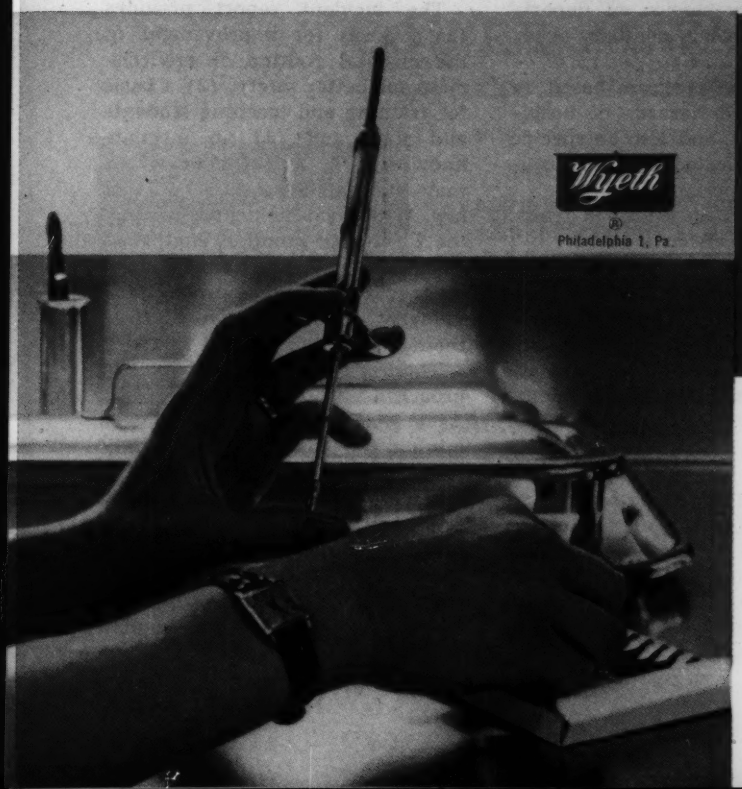
Don't Waste Your Nurses!

Time-motion study[1] proves TUBEX saves 38% of nursing injection time!

Does the conventional injection method waste nurses' time? Time-motion analysis says, *Yes!* Studies[1] of procaine penicillin injection in a 366-bed hospital show that the TUBEX closed-system technique cuts 1 minute 19 seconds—a saving of 38%—from the average time required by nurses in their injection duties. With a workload in this hospital of 21,150 procaine penicillin injections in 1956, conversion to TUBEX *for these injections alone* would have saved 466 nursing hours, or 58 8-hour nursing shifts, more than enough to provide another nursing shift every week.

What Does This Mean to You? As a hospital administrator, you are concerned with nursing efficiency. TUBEX disposable units—available in a wide range of medications—cut nursing time significantly. Apply the savings in nursing hours to other vitally needed nursing services! *Test all the values of* TUBEX *in your own hospital!* Mail the coupon today!

1. Hunter, J.A., et al.: Hospital Management *83*:86 (March) 1957.



TUBEX®

CLOSED-SYSTEM INJECTION

WYETH LABORATORIES
P.O. BOX 8299
Philadelphia 1, Pa.

Yes, I am a hospital administrator interested in hospital efficiency. Please rush samples of TUBEX, without obligation, so that I may study closed-system injection in my own hospital.

Name_____

Hospital_____

City_____ State_____

scious effort in the direction of safety. Here are some of the results:

- Total number of work injuries, down 45 per cent.
- Disabling injuries, down 53 per cent.
- Total direct costs, down 85.5 per cent.
- Days lost from disabling injuries, down 85.5 per cent.
- Frequency rate, disabling injuries per million man hours, down 53 per cent.
- Average direct costs per disabling injury, down 72 per cent.

One part of our program is our participation in the safety contest conducted jointly by the American Hospital Association and the National Safety Council. It is a five-dollar annual investment. There is a class for every size hospital and each hospital entered can compare its own records with those of other hospitals of the same size. Every hospital would gain from participation in these activities. The hospital contest standings are based on the reported frequency rate, which is the number of disabling injuries recorded per million man hours worked. Our own frequency rate during the year ended June 30, 1955, was 5.8. A year later it was down to 2.7 and for the calendar year 1956 it was down to 1.69. This meant five disabling injuries for slightly under three million man hours.

By comparison, the last hospital in our class reported a rate of 36.46. We calculated that if we had experienced that rate instead of our own, we would have had not 5 but 106 disabling injuries. Using our average costs for 1955 ($568.64), such a record would have given us total losses of more than $60,000. Our actual losses during the period were under $2000.

One other example. Insurance costs in a 400-bed New York hospital totaled $48,500 in 1952 and jumped to $82,000 in 1953. The hospital's insurance carrier gave up the battle as a losing proposition. Another insurer asked a deposit premium of $95,000 and imposed a safety program, directed by their own safety engineer. It paid off. He got back $32,000 the same year, and in 1955 the cost was down to $56,580.

MECHANICS OF PROGRAM

What are the mechanics of a hospital safety program? Briefly, they are these:

1. Technical guidance from a specialist, such as an insurance company safety engineer, in matters of safety, and from a qualified fire prevention man in fire details.

2. Technical advice available by subscription. Our maintenance supervisor is a member of the National Fire Protection Association. The hospital subscribes to the combined safety services of the National Safety Council and the American Hospital Association. These two memberships provide literature and technical information every hospital should have.

3. Personal interest of the administrator; active participation.

4. A high level committee organization for safety, or better still, a safety session of department heads every month or every two weeks.

5. An action program based on the recognized hazards of hospitals generally, and also on specific problems indicated by the hospital's own experience.

6. Emphasis on safety in training and supervision.

7. Integration of safety into the routine is perhaps the most significant part of the program—getting work procedures under control and encouraging good attitudes in individual staff members.

SAFETY OF PATIENTS

The safety of patients and visitors is even more important than that of the staff with regard to (a) public relations and (b) losses. Claims have resulted in verdicts up to $200,000. The average figure for settlements went up 83 per cent between 1940 and 1950. Charity is no longer a valid defense in most states.

In California, 130 associated hospitals not long ago entered an intensive patient safety program intended to meet the liability problem head-on. Here is what they did:

- Required each hospital to produce complete and accurate incident reports on all happenings to patients out of the ordinary routine.
- Set up central punch card records to analyze data received from all members.
- From data so analyzed, devised measures to prevent similar accidents.
- Applied these measures in all member hospitals.

This and other safety matters are perpetual problems, which, when not under control, erupt periodically in costly incidents and very damaging publicity.

Individually, hospitals should all be doing some of these things. Incident reports should be prepared faithfully on every incident. These should be tabulated—how many falls out of bed? how many falls in bathrooms? how many medication errors? and so on. The nursing committee at our hospital has gone a step further, and has special forms for analysis of falls out of bed and medication errors.

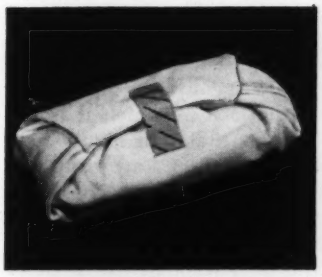
The incident report provides (1) a basis for improvement of the hospital routine or environment for better safety, (2) a basis for training and teaching students and staff, and (3) an intimate knowledge of an incident which may some time reach a court of law. With good incident reporting, the California group strengthened their legal defenses tremendously; other hospitals can profit individually and collectively from their experience.

These are only some of the approaches to safety in the hospital. As a general criterion for determining the course of any safety program, many favor this one: "If it works, use it." There is no single best way to apply safety in all hospitals. But there is no question about the continuing need for promoting it continuously, because it pays off in both tangible and intangible benefits. ■

ONLY HIGH STEAM TEMPERATURES can bring out these distinctive markings on "SCOTCH" Hospital Autoclave Tape No. 222.

YOU'RE ALWAYS SURE...

with "SCOTCH" Hospital Autoclave Tape No. 222



LEAVES NO STAINS or gummy residue! "SCOTCH" Hospital Autoclave Tape No. 222 is the only tape that holds firmly in high steam temperatures, yet peels off neatly without discoloring linens. It seals packs in half the time required for pinning, tying or tucking, takes pencil or ink markings.

NO CHANCE OF ACCIDENTAL ACTIVATION of this tape – radiator heat or sunlight doesn't affect the special inks used in "SCOTCH" Hospital Autoclave Tape No. 222. It takes the sustained high steam temperatures of the autoclave to make those distinctive diagonal markings visible – and you can see them clear across the room! *This is not positive proof of sterility, of course – nothing on the outside of a bundle can prove that.*

See your surgical supply dealer now for "SCOTCH" Hospital Autoclave Tape No. 222 and new tape-saving dispensers!

Reg. U.S. Pat. Off.

SCOTCH BRAND **HOSPITAL TAPES**

• TIME-SAVING • WORK-SAVING • MONEY-SAVING

PRODUCT OF 3M COMPANY RESEARCH

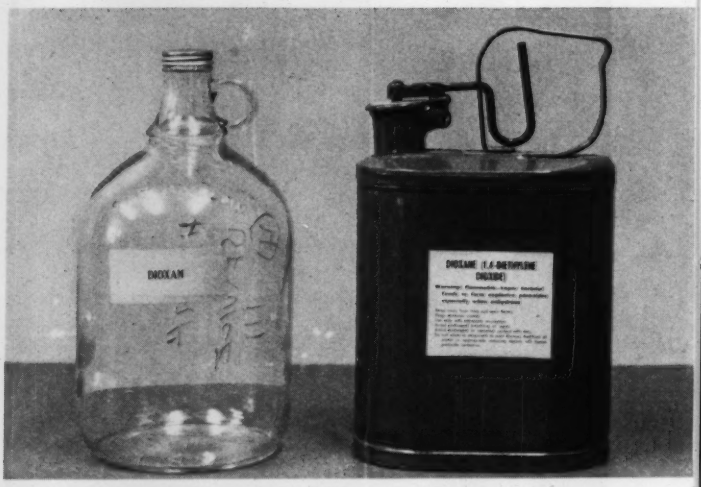
The term "SCOTCH" is a registered trademark of Minnesota Mining and Manufacturing Company, St. Paul 6, Minn. Export Sales Office: 99 Park Ave., New York 16, N. Y. In Canada: P.O. Box 757, London, Ontario.

CARBON DISULPHIDE 3ML
BENZENE 9.5 ML
CARBON TETRACHLORIDE 3.7 ML
DIOXANE 26 ML
WHEN THE FOLLOWING AMOUNTS ARE VAPORIZED IN THIS LAB
THE AIR CONCENTRATIONS WILL BE DANGEROUS TO HEALTH
NITROBENZENE 3ML
METHYL CELLUSOLVE 6 ML
CHLOROFORM 26 ML
XYLENE 76 ML

solvents, caustics, insecticides, bleaches— all are potential

occupational hazards that can be overcome

by GEORGE S. MICHAELSEN



TOP: This display at University Hospitals is an effective illustration of the toxicity of solvents common to hospital laboratory and service operations. ABOVE: the right and wrong ways to store and label toxic chemicals: The label on the bottle at left tells nothing about the dangerous properties of its contents, and the container itself is dangerous. Can at right is an approved container properly labeled for toxic chemical storage.

Many potential occupational health hazards are associated with the operation of a hospital, the author states. He lists a number of hazardous materials and situations, explaining how an intelligent preventive program and an alert awareness of the possibilities can help overcome these hazards.

A PARADOXICAL situation exists in the hospital field. The purpose of the hospital is to restore the sick to the fullest possible measure of health and well-being. In so doing, however, we may unwittingly create hazards which, if completely disregarded, may lead to serious illness and even death for operating personnel subjected to them. Some of the hazards discussed here are obvious and others are not so obvious, but all are serious enough to deserve attention in the hospital safety program or employee training manual.

SOLVENTS

Volatile solvents are used extensively in the maintenance shops, offices, and laboratories, and in housekeeping procedures. Because they present either a health hazard or a fire hazard or both to the user, they must be used with extreme caution.

Of the solvents commonly used, carbon tetrachloride is the most dangerous from a health standpoint. It has found wide acceptance because a fire hazard does not result from its use, and it is an excellent solvent for cleaning electrical equipment, office machinery, and spotting furniture, drapes, and rugs.

A large number of deaths have occurred throughout the country from the misuse of carbon tetrachloride. Here are a few examples from a list of 147 deaths tabulated a few years ago: Cleaning furniture (2 deaths), cleaning an office (1 death), using carbon tetrachloride fire extinguishers (16), using a mop soaked in carbon tetrachloride (1), cleaning glue off of a newly laid floor (1), cleaning floors (2), removing paint (2), cleaning machinery in a small room (1), refrigerator repairman cleaning a refrigerator (1), electrician using carbon tetrachloride to dry an electric motor (1). All of these activities might be perfectly normal procedures in a hospital. In each case the wrong solvent was used.

Carbon tetrachloride should *not* be made available to hospital personnel as a general solvent. Its use should be strictly limited to those situations in which it is the only solvent that will do the job. Fortunately, there are suitable substitutes available on the market. One substitute, available under various trade names, is methyl chloroform. Although the toxicity of methyl chloroform is only 1/20th that of carbon tetrachloride, it still cannot be used with reckless abandon. It is moderately toxic, and exposure to the vapors should be kept to a minimum.

Benzol is another extremely dangerous solvent from a health

George S. Michaelsen is associate professor, School of Public Health, and industrial health engineer, University Health Service, University of Minnesota.

FREE YOUR NURSES FOR NURSING...

Let our machines wrap your dressings

TELFA SPONGE PADS. #196—Pre-Pack non adherent unit dressing. 9" x 5". Cut labor costs 50%.

ABDOMINAL Pads #179—8" x 7½"; #109—10" x 8". Individually pre-packed, ready for the autoclave.

COVER SPONGES #641—Pre-Pack 2 to envelope. 4" x 4". 25 packs (50 sponges) in disposable tray for easy handling.

Pre-Pack Curity post-operative dressings slash your biggest single cost—Labor

You of all people know how hospital costs have been going up . . . up . . . up.

Since 1946, the cost of everything but labor is up 101%. And labor costs are up a whopping 186%! So anything that helps you save on labor cuts your biggest single expense.

That's why so many hospitals are switching to Curity Pre-Pack post-operative dressings. Pre-Pack Curity functional dressings come to you ready for use. (Our machines do the time-consuming job of counting, folding, wrapping, labeling and sealing.)

Published hospital reports show savings of up to 20%—just by switching to labor-saving Curity Pre-Pack dressings. Isn't it time for *you* to switch, too? See your Curity representative.

Curity® PRE-PACK **HOSPITAL DRESSINGS**

BAUER & BLACK Division of The Kendall Company

and fire standpoint which may find its way into a hospital. It is an excellent solvent and is a common constituent of paint removers. Benzol's principal effects are on the blood and blood-forming organs. It is reported to have a long delayed action so that the effects of overexposure may not be apparent for months or years.

Other solvents likely to be used in a hospital include toluene, xylene, acetone and alcohol. These are of less importance from a health standpoint unless grossly misused but very dangerous as a fire hazard. Most solvents have a tendency to remove the natural protective oil from the skin and thereby increase the possibility of troublesome dermatitis. If it is necessary to use a solvent for a variety of purposes in a hospital, it should be selected very carefully so as to present minimum poisoning and fire hazards.

ACIDS AND ALKALIES

Housekeeping personnel, maintenance men, dietary personnel, laundry workers, laboratory technicians, and firemen come in contact with a variety of acids and alkalies. These include bleaches, drain cleaners, alkaline degreasers, washing compounds, and boiler water treating compounds. The main hazard from exposure to these materials is dermatitis in sensitive individuals. This can be minimized by protective gloves and hand creams.

INFECTIOUS WASTES

The handling of infectious waste or containers that have been in contact with infectious materials frequently causes concern among laundry, maintenance, and housekeeping personnel. This is particularly true in communicable disease hospitals. Prime responsibility for the prevention of the spread of bacterial contamination and communicable diseases rests with the medical and nursing staff. If isolation techniques do not break down, there should not be any hazard to the other operating personnel of the hospital. It would be well, however, for the administrator to check from time to time on the isolation practices to be reassured that the procedures are actually followed and to serve as a reminder to the medical and nursing staff that they have a responsibility to the other members of the hospital staff. In this connection, it is generally advisable to immunize laundry, maintenance and housekeeping personnel against typhoid, diphtheria, smallpox, and tetanus.

INSECTICIDES

In recent years a widening variety of insecticides under a multitude of trade names have introduced potential health hazards to hospital personnel and patients. Fortunately, a number of very effective insecticides are quite harmless to humans, but there are some that are very poisonous and should not be used in occupied buildings. It may well be that for the small hospitals the solution lies in having the work done by a qualified licensed exterminator or pest control officer. In any case, the administrator should be somewhat familiar with the toxic properties of insecticides.

Insecticides may be grouped into two classes, organic and inorganic compounds. The vast majority of them are organic compounds. A number of the organic insecticides are complex chlorinated hydrocarbons. Aldrin, dieldrin, chlordane, lindane, DDT, and methoxychlor, the most common of this type, are useful in killing household insects. These materials are poisonous to humans also. Aldrin, dieldrin, and chlordane are too poisonous to use in a hospital. Lindane, DDT, and methoxychlor may be used if extreme precautions are employed to avoid contamination.

Caution should be observed in using lindane vaporizors. When these devices were first introduced it became apparent that there would have to be some way of controlling the amount of material vaporized and that certain locations should be avoided. It was suggested that the rate of vaporization should not exceed one gram per 15,000 cubic feet of space per 24 hours, and that there be a thermostatic control to prevent overheating of the lindane. As experience with these devices has been gained, it has become apparent that they must never be used where food is processed, served, or stored. Nor should they be used in hospital wards or any sleeping quarters.

Parathion, diazinon, dipterex, and malathion are examples of organic phosphate insecticides. These are extremely poisonous to humans and none of them should be used in a hospital. Fortunately, there are a number of excellent organic insecticides available which are relatively harmless to humans and therefore suitable for use in a hospital. These include pyrethrin, allethrin, piperonyl cyclonene, piperonyl butoxide, and rotenone.

The inorganic insecticides include calcium arsenate, arsenic trioxide and a variety of fluoride compounds. These are all toxic to humans and their use in hospitals should be discouraged.

OTHER HAZARDOUS MATERIALS

In addition to these general problems there are the more specialized problems of bacterial infection and mercury poisoning in laboratory workers, the possibility of overexposure to ionizing radiation on the part of x-ray technicians and persons handling radioactive isotopes. The nuisance of excessive dust in glove dusting and testing should not be overlooked.

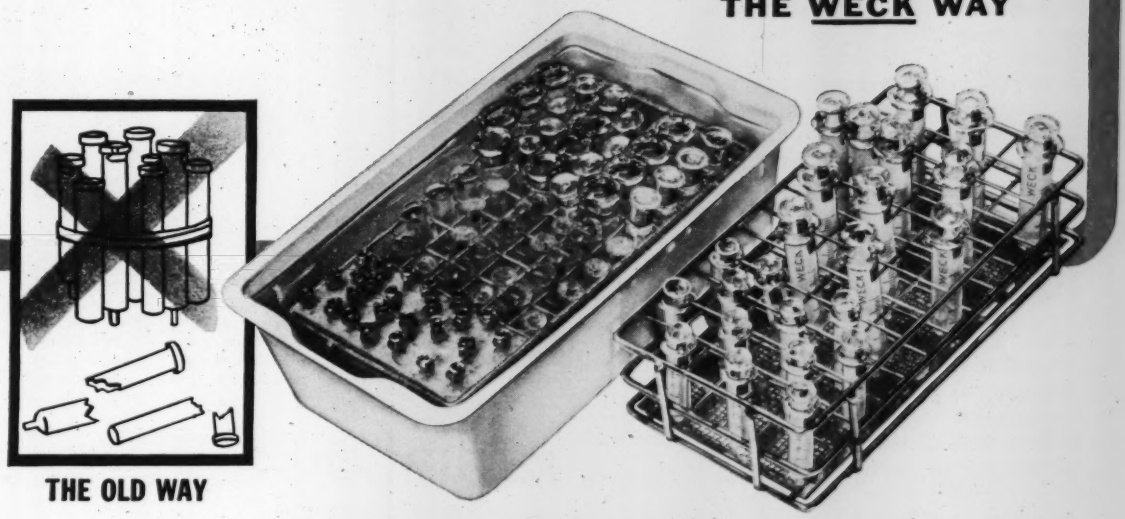
It may seem that the hospital is a particularly dangerous place to work, but such is not the case. Fortunately, all the potential hazards are not likely to become real hazards at the same time, but it is important to create an awareness of the possibilities and act to minimize the actuality of the hazard. Following are some things that the hospital administrator and supervisory personnel can do to reduce the hazards in his institution.

Custodial workers often have

NOW—A SAFE, SIMPLE, EFFICIENT METHOD

—for handling soiled syringes and needles!

THE WECK WAY



THE OLD WAY

WECK
SYRINGE AND NEEDLE RACK

The Weck method is simplicity itself. After use, the syringes are disassembled with plungers, barrels and needles placed in rack in soak basin containing solution of Weck Cleaner. As shown (left above) needles are inserted in cellulose sponge.

Hospitals the country over are finding the Weck Syringe and Needle Rack offers many specific advantages:

- **Guards personnel against danger of contracting infectious hepatitis.**
- **Sponge holding needles can be pre-sterilized adding further protection to personnel.**
- **Simplifies syringe and needle washing since soaking dissolves medication and blood and prevents blocked needles.**
- **Reduces syringe handling thus minimizing breakage. Entire rack with syringes placed in automatic washer as a single unit.**
- **Protects needle points from damage after use, thus lowering needle replacement.**
- **Simplifies counting and checking of returned syringes.**
- **At all stages of transporting and storing syringes the rack acts as a container—a positive control—instead of former haphazard handling of individual units.**

DRY HEAT STERILIZATION—Syringes can be issued, soaked, returned, washed in a syringe washer, dried, capped and sterilized — all in the Weck rack.

Cat. #	Syr. & Needle Rack	Capacity	Price
61-110	2 & 5 cc.	54 syringes	$15.00
61-210	10 & 20 cc.	24 "	13.50
61-310	30 & 50 cc.	12 "	13.50

Cat. #	Syringe Rack	Capacity	Price
61-100	2 & 5 cc.	72 syringes	$15.00
61-200	10 & 20 cc.	32 "	13.50
61-300	30 & 50 cc.	18 "	13.50

SOAK BASIN — #61-250 — Durable, heavy gauge plastic, light in weight, will hold any size Weck Syringe and Needle Rack. White in color, easily cleaned, noiseless — $3.00.

67 years of knowing how

EDWARD WECK & CO., INC. 135 Johnson St., Brooklyn 1, N. Y.

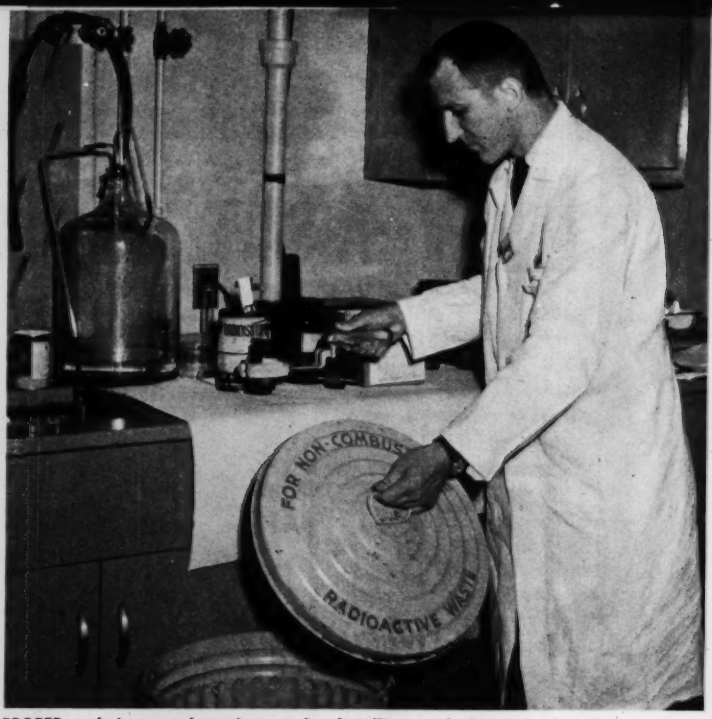
Manufacturers of Surgical Instruments • Hospital Supplies • Instrument Repairing

their own mixtures of cleaning compounds which they feel are superior to anything on the market. Unless it is positively known that there is no particular hazard in such preparations, their use should be strictly forbidden. Recently a custodial worker prepared his own furniture polish and before he had a chance to use it the bottle blew up. It may have been a good furniture polish, but obviously a dangerous one.

On the whole, it is doubtful that a custodial worker will have a better material than is available from a manufacturer of such products. This, however, is not the complete answer, for some of the commercial products *do* contain poisonous materials. A declaration of content should be furnished for any product, and those containing highly toxic materials should be avoided. Use of the most toxic and most flammable solvents, either in a pure state or mixed with other cleaning agents, should be avoided completely. If there is doubt about the toxicity of a preparation, the hospital toxicologist or state or local health department should be consulted for a definite ruling.

Where there is a contact between harsh chemicals and skin, supervisors should insist on the use of protective creams, gloves, or other garments as the circumstances may dictate. When the protection of a part of the personnel depends upon the actions of others, as in the handling of infectious waste, periodic inquiries should be made to see that the proper procedures are actually being carried out. Administrative personnel should listen for possible work-related illnesses when hearing employees' complaints about unsatisfactory working conditions or ill health.

There are many potential occupational disease hazards associated with hospital operation. An intelligent preventive program and an alert awareness of the possibilities can help keep them to a minimum. ■



PROPER technique and equipment for handling and disposal of radioactive contaminated waste are demonstrated at University Hospitals.

radiation—

helpful friend and deadly enemy

providing full information—in writing—about hospital radiation hazards is an administration responsibility of growing importance

by **RALPH O. WOLLAN**

THE INCREASED use of radioactive materials throughout the country has stimulated a growing concern over the hazards associated with their use. The potential dangers of excessive exposure to the radiation from these materials has instilled in most of us a respect for these hazards. Based on this respect and growing knowledge of the scope of the hazard, we have developed and are continuing to develop sound practices in the safe use of radioactive materials.

There are hundreds of different kinds of radioactive isotopes emitting different types of radiation covering a broad range of energies, with half-life periods from a few seconds to millions of years. Some of the materials emit radiations so soft that they can be stopped by a sheet of paper; others must be housed in lead containers with thick lead walls to reduce the radiation to a safe level.

Ralph O. Wollan is a health physicist, University Health Service, and an instructor, School of Public Health, University of Minnesota, Minneapolis.

TYPES OF RADIATION

Some of these radioactive materials in very small quantities may be safely handled in the laboratory with no elaborate protective measures. Others must be handled with extreme care to prevent the worker from exposure to the dangerous effects of its ionizing radiation.

Radioactive materials which emit alpha radiation, such as

MAYBE you've noted it yourself in recent months: the familiar blood bottle of rigid glass is being replaced more and more often by a plastic bag. What's behind this shift? Some advantages of a bag are easily seen. Other advantages, equally important, are perhaps not so obvious. But turn over leaf.

PLIAPAK®

Abbott's disposable plastic container

What you can do with PLIAPAK®

Abbott's disposable plastic container

1 **Collect blood** The PLIAPAK collects blood by gravity, using a closed system which is virtually airfree. The bag fills gently, expanding to admit the blood without foaming or turbulence. A collection set is included, with plastic tubing and siliconed needle, providing a completely nonwettable blood path.

2 **Preserve blood** PLIAPAK's plastic surfaces and closed gravity technique preserve the cellular components of whole blood from trauma. Hemolysis is avoided and there is no "wettable" surface to which platelets can adhere. Each PLIAPAK contains ACD solution for the preservation of 450 cc. blood.

3 **Process blood** Serology samples are easily obtained from the collection tubing without disturbing the contents of the bag. The PLIAPAK may be centrifuged in any standard 500-cc. water-filled cup. Plasma, platelets, and red cell mass may be separated and withdrawn for individual infusion.

4 **Transport and store blood** The PLIAPAK is tough and tamperproof, and minimizes problems of breakage. These qualities make it the ideal container for ambulance and disaster use. PLIAPAK takes little shelf space, and can be stored flat on its side even when filled. It may be incinerated after use.

5 **Infuse blood** No air is admitted; the bag simply collapses as it is evacuated. Thus a potential source of air embolism is eliminated, and any air-borne contaminants are excluded. In emergencies the attendant can instantly force blood into the vascular tree without additional apparatus, simply by squeezing the bag, or by slipping it under the recipient's shoulders or buttocks. The PLIAPAK accepts any standard administration set, including series and alternating hookups. Abbott

Talk to your Abbott service representative about the benefits of PLIAPAK for your own hospital

711024

plutonium^{239}, which is a bone-seeking isotope when taken internally, present no external radiation hazards but must be carefully controlled to prevent their getting into the body by inhalation, injection, or through breaks in the skin. Beta emitters, such as strontium 90, fall somewhat in the same category, and internal access to the body must be prevented by careful handling and storage, as well as by the use of both local and general ventilation.

A minimum of shielding to reduce the external hazards may be required for materials emitting mildly penetrating beta radiation. Radioactive materials which emit gamma rays—radium and cobalt 60, for example—fall into a somewhat different class. Such gamma emitters must be adequately shielded to reduce the radiation to a safe level. Lead and concrete serve as effective gamma ray shields, and may be fabricated into "pigs" used for storage of radioactive materials.

All areas where radioactive materials are used should be marked with approved radiation warning signs, including the accepted symbol and colors for radiation hazards. Special provisions should be made for routine surveys of the laboratory to determine the extent of the hazard in the area, as well as to minimize the spread of contamination through the hospital.

EXACT RECORDS VITAL

Records should be kept of the exact location of all radium and cobalt 60 capsules, including the name of the person responsible for their use. Particularly in the case of radium, routine surveys by a competent expert should be made of the capsules to determine their condition from the standpoint of leakage. Maximum permissible levels (M.P.L.) for radium contamination in the air are extremely low; consequently, extreme care should be taken in their use, transportation throughout the hospital, and storage, in order to prevent damage to the capsule and release of the material into the air.

The serious consequences of the accidental release of radium were demonstrated at an eastern industrial plant. A half-inch long 25-mg. radium capsule about as thick as a knitting needle ruptured through careless handling. It took four months of tedious decontamination to make the building usable and cost approximately $250,000 for the cleanup operation.

There are a number of cases in the literature in which the careless handling of radium sources in hospitals has after long periods of time become apparent only after radiation surveys have been made of storage and handling areas. One hospital reported that radium capsules—or radium sources as they are more often called—were found in the basement in unused lead containers which were thought to be empty. No records of the location of the capsules or knowledge of their loss were available. Surveys of the sources on hand revealed gross leaks in a number of them. With good records, periodic radiation surveys, and a conscientious effort toward radiation safety, this need not be an area of more than normal concern.

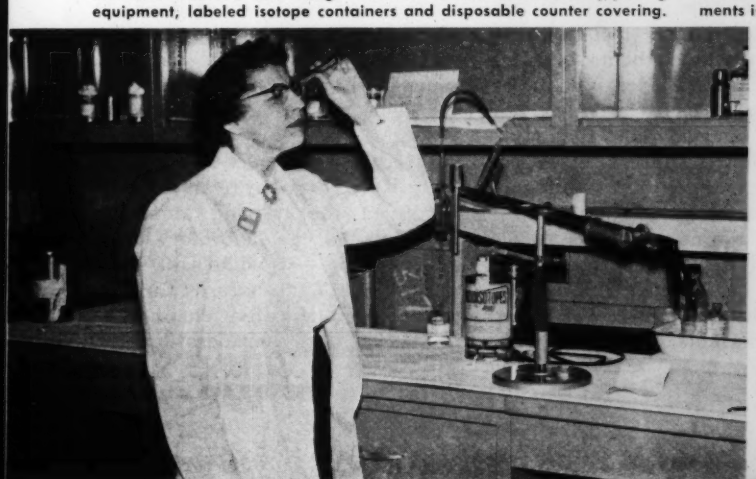
MEASURING RADIATION

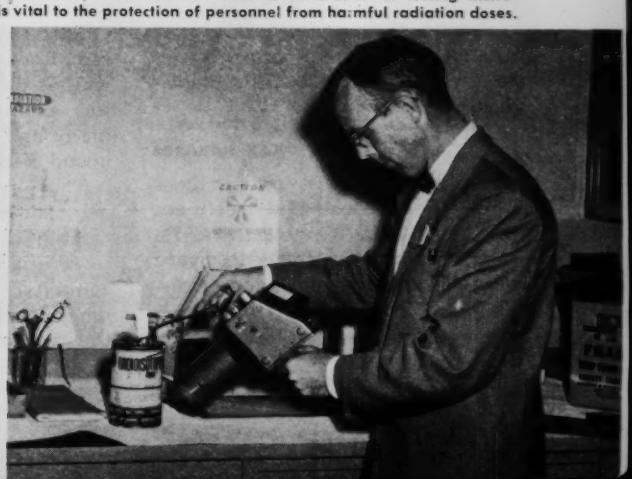
It is impossible to smell, hear, see, or even feel ionizing radiation; for this reason, good instrumentation is an essential for proper hazard evaluation. Unfortunately, there is no one instrument that will measure all types of radiation effectively. Advice should be obtained from an expert prior to selection of expensive equipment for accurate radiation measurements. The production of such equipment has become a tremendous business in the last 10 years and a broad variety of instruments in a variety of prices is available.

The importance of routine calibration of these instruments cannot be overemphasized. Having no instrument at all is better than having one which is poorly maintained, as poor calibration may lead to a false sense of security in areas where radiation hazards exist. Measurements of the radiation levels around x-ray equipment and isotope laboratories and in rooms adjoining cobalt 60 teletherapy machines, for example, are of obvious concern in the evaluation of the extent of the potential hazard. However, the ultimate goal in radiation safety or health physics, as it has come to

LEFT: University Hospitals staff member uses radiation monitoring dosimeter and wears a film badge. On the counter are remote pipetting equipment, labeled isotope containers and disposable counter covering.

RIGHT: Author Wollan uses a monitoring device to test for contamination of laboratory work counter. Routine calibration of testing instruments is vital to the protection of personnel from harmful radiation doses.





be known, is to evaluate as accurately as possible what the radiation exposure is to the individual.

Personnel monitoring devices in the form of radiation sensitive film badges should be worn by those in an area where the likelihood of a significant external exposure exists. This has been interpreted by the Atomic Energy Commission as an area in which one can receive one-fourth of the maximum permissible weekly dose of 0.3 rem. (a unit of measure of radiation exposure). Even 0.3 rem. per week can no longer be considered acceptable on a continuous basis. The maximum permissible dose per year has recently been revised downward to 5 rem.

Film badge service can be purchased commercially through a number of companies. Assurance on the part of administration that personnel radiation exposures are well within the safe level is compensation enough for the cost of the service. Badge records serve a valuable two-fold purpose.

First, they indicate the amount of radiation exposure for the period the badge was worn, whether it was a week or a month. This information can point out poor techniques on the part of the isotope handlers or it may reveal a disregard for personnel safety on the part of an x-ray technician. Again, it may indicate the need for a rotation program for nurses caring for radium patients. Badge records provide immediate information for followup on the radiation protection program.

Second, the exposure record, if well kept, may be of future value to the institution from a medicolegal standpoint.

X-RAY HAZARDS

X-rays have been used in hospitals for diagnosis and treatment for more than 50 years. Only a few months after their discovery in 1895, accounts of radiation injuries to users began to appear. Even today, after the long experience with this type of radiation equipment, it continues to constitute a significant source of radiation exposure to operating personnel. A complete survey of all medical x-ray equipment from the standpoint of radiation safety to the operator and associated personnel as well as the patient would be time well spent.

The National Academy of Sciences in a recent report on the biological effects of radiation has directed attention toward the genetic effects of ionizing radiation. Maximum allowable limits of radiation exposures published prior to this time took into consideration primarily physiological damage. These levels have very recently been revised downward to take into consideration the effects of radiation-induced genetic mutations on future generations.

Newly established radiation limits emphasize the reduction of radiation exposure to persons in the reproductive years, and put a premium on the older person as a safer risk in work which involves possible radiation exposure. This does not detract from the importance of the physiological effects of radiation damage but projects our thinking to our moral obligations to future generations.

SCOPE OF RESPONSIBILITY

This paper is not intended to outline a complete program for radiation safety in the hospital. The intent here is to call to the attention of hospital personnel their broad responsibility to those likely to be exposed to sources of ionizing radiation.

This responsibility includes the radiation workers themselves as well as the nurses aides, who may, for example, bring patients to x-ray and restrain them for diagnostic x-rays.

They include the nurse in surgery during the implanting of radium, or the nurse who is asked to return the radium to a storage container, or the custodial person who may be involved in emptying the wastebaskets in which isotopes have been carelessly disposed, or the physician who fails to inform the nurse that cobalt 60 needles should not be carried with the fingers, but with long tongs or better yet in properly shielded containers.

The responsibility may include the new researcher who takes over a laboratory which was grossly contaminated prior to his arrival, or the orderly who never was informed that urine from a iodine 131 therapy patient may be grossly contaminated.

These are but a few examples of situations which can arise when sources of radiation are used which affect groups having no direct connection with the radiation project. Some of these situations could produce serious physiological damage to the individual. Others may grossly contaminate extensive areas before detection. Some may produce only nuisance situations in which the work in counting rooms and research laboratories may be interrupted because of the spread of contamination.

Proper training of all personnel in at least the basic concepts of radiation protection is essential if they are to work with any source of ionizing radiation. It is the responsibility of hospital administration to be certain that all persons working with radioactive materials are aware of the potential hazards they might encounter. The less the technical knowledge the employee has regarding radiation, the greater the moral obligation to those who supervise the project.

For a project director to be aware of the potential hazards is of limited value if he fails to pass this information on to all who could, through their association with a project, be exposed to radiation. The nurse who cares for a patient undergoing radiation diagnosis or treatment must first be made aware of the radiation situation, then must be trained in the special techniques of radiation protection. If they can be endangered, the nursing aide, the hematologist, the laboratory technologist, the custodian, all must be advised of the hazards through proper administrative channels.

Taking into consideration the

This single White Latex Quixam Examination Glove fits either hand. Available in small, medium, and large sizes.

This Green Neoprene Quixam Examination Glove for persons allergic to natural latex. Small, medium, and large sizes.

Economical Quixams®

...For Examinations, Dressings & Treatments

- A single glove fits either hand comfortably
- An inexpensive glove that withstands 10 to 20 sterilizations
- Eliminates broken pairs... any two of a size make a pair

the PIONEER Rubber Company

349 Tiffin Road • Willard, Ohio

Pioneers in Surgical Hand Protection for over 35 Years

general lack of knowledge about ionizing radiation, it is not sufficient to notify custodial personnel, for example, that a hazard exists. They are not in a position to evaluate such a hazard, and consequently need guidance. Instructions to these persons should almost without exception be given in writing and if necessary, explained by someone competent in the field of radiation hazard evaluation.

We have learned to work safely with hazardous materials of other kinds by designing equipment and providing special facilities required by the nature of the hazard. Similarly, with ionizing radiation, there are practical solutions to the problems presented. With proper training in the safe handling of radiation emitters, with adequate equipment and instrumentation and with a keen respect for the potential hazards associated with their use, there may be no limit to the scope of radiation applications in the field of medicine. ■

how to control food-borne disease in the hospital

by LEE D. STAUFFER

PROVIDING equipment that can be easily taken apart for cleaning is one way of helping to build in sanitation and to reduce the infectious process in hospital food service operations.

The author outlines the ways in which infectious disease is developed and transmitted and the methods for controlling the onset and spread of food-borne disease in hospital food service operations.

IN AN OREGON hospital a kitchen employee, thinking she was adding powdered milk, mixed 17 pounds of cockroach powder with 10 gallons of scrambled eggs and served them for breakfast. Forty-seven persons died.

In an Alabama institution, raw cabbage, taken from a patch near peach trees that had recently been sprayed, was used in making salad. The cabbage was supposedly washed. Sixty persons were hospitalized with arsenic poisoning.

A ham was allowed to remain overnight at room temperature in a Los Angeles hospital. This ham, plus two-day-old turkey leftovers, improperly refrigerated, were used to make sandwiches the next day. Forty-six persons ate the sandwiches and 37 had severe gastroenteritis within eight hours.

In an Illinois institution contaminated frozen eggs, used to make eggnogs, were the cause of salmonellosis in six patients. In other places, contaminated dried egg-yolk powder caused salmonellosis in infants.

These examples are but a few of the many case reports that are received each week by the National Office of Vital Statistics of the Public Health Service, telling of mistakes and flaws in food service operations that have caused sickness or death. In each case, someone has taken food sanitation for granted.

GREATER PRECAUTION FOR HOSPITALS

Unfortunately, food sanitation is often taken for granted in the

Lee D. Stauffer is sanitarian, University Health Service, and instructor, School of Public Health, University of Minnesota, Minneapolis. This article is adapted from an address given at the Upper Midwest Hospital Conference, May 1956.

YOU WON'T FIND IT ON THE LABEL

A fact which the Puritan label does *not* reveal is that the Puritan people have long been authorized sales representatives for leading makes of anesthesia machines and accessories.

Just as you have learned to rely on the quality of Puritan's own equipment, you can depend on Puritan for the finest in service on these other makes of equipment, from Puritan's wide network of sales offices.

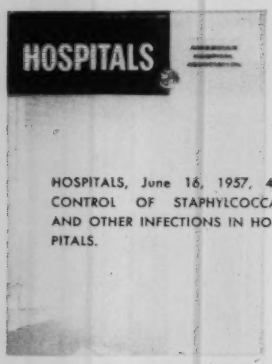
Puritan PURITAN MAID

COMPRESSED GAS CORPORATION
SINCE 1913
KANSAS CITY 8, MO.

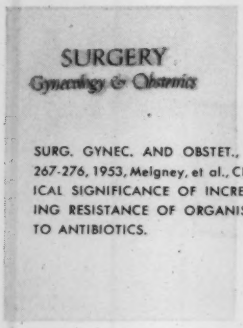
PRODUCERS OF MEDICAL GASES
AND GAS THERAPY EQUIPMENT

Strengthen Your

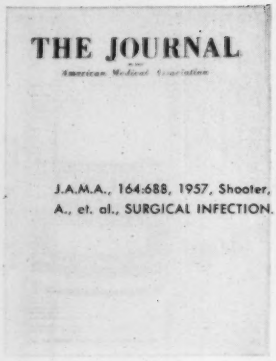
RECENT PUBLISHED STUDIES ALERT HOSPITALS TO INCREASING CROSS-INFECTION HAZARDS



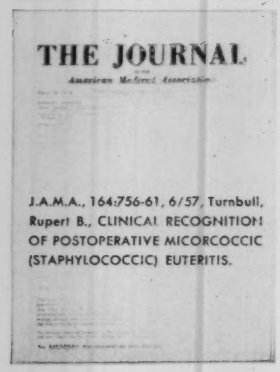
HOSPITALS, June 16, 1957, 47, CONTROL OF STAPHYLCOCCAL AND OTHER INFECTIONS IN HOSPITALS.



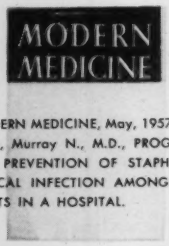
SURG. GYNEC. AND OBSTET., 92: 267-276, 1953, Melgney, et al., CLINICAL SIGNIFICANCE OF INCREASING RESISTANCE OF ORGANISMS TO ANTIBIOTICS.



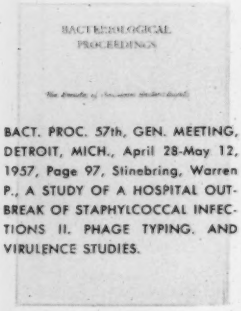
J.A.M.A., 164:688, 1957, Shooter, R. A., et. al., SURGICAL INFECTION.



J.A.M.A., 164:756-61, 6/57, Turnbull, Rupert B., CLINICAL RECOGNITION OF POSTOPERATIVE MICORCOCCIC (STAPHYLOCOCCIC) EUTERITIS.



MODERN MEDICINE, May, 1957, 73, Levin, Murray N., M.D., PROGRAM FOR PREVENTION OF STAPHYLOCOCCAL INFECTION AMONG PATIENTS IN A HOSPITAL.



BACT. PROC. 57th, GEN. MEETING, DETROIT, MICH., April 28-May 12, 1957, Page 97, Stinebring, Warren P., A STUDY OF A HOSPITAL OUTBREAK OF STAPHYLCOCCAL INFECTIONS II. PHAGE TYPING. AND VIRULENCE STUDIES.

BIBLIOGRAPHY

MODERN MEDICINE, May 1, 1957, 73, Levin, Murray N., M.D., PROGRAM FOR PREVENTION OF STAPHYLOCOCCAL INFECTION AMONG PATIENTS IN A HOSPITAL.

MEDICAL SCIENCE, May 25, 1957, Bahnson, Henery T., M.D., et. al., STAPHYLOCOCCAL INFECTIONS OF THE HEART AND GREAT VESSELS DUE TO SILK SUTURES.

"MEMORANDUM", May 22, 1957, Wetzler, T. F., M. PYOLGENES VAR. AUREUS. ITS IMPORTANCE IN HOSPITAL SANITATION. BACKGROUND AND DEVELOPMENT.

J.A.M.A., 164:83, 5/57, Lund, Flemming, RESISTANT MICROCOCCI.

J.A.M.A., 164:796, 6/57, MICROCOCCIC BRONCHOPNEUMONIC.

J.A.M.A., 164:756-61, 6/57, Turnbull, Rupert B., CLINICAL RECOGNITION OF POSTOPERATIVE MICROCOCCIC (STAPHYLOCOCCIC) EUTERITIS.

J.A.M.A., 164:201, May, 1957, MICROCOCCIC PNEUMONIA.

J.A.M.A., 164:321, May, 1957, Cook, et al., MICROCOCCIC DIARRHEA.

J.A.M.A., 164:688, 1957, Shooter, R. A., et. al., SURGICAL INFECTION.

J.A.M.A., 164:669, June, 1957, CROSS INFECTION FROM THERMOMETERS.

AMER. J. PUBLIC HEALTH, 47, (5):612-613, 1957, Bondi, Amedee, et. al., LABORATORY AND PUBLIC HEALTH ASPECTS OF THE INCREASE IN INFECTION DUE TO ANTIBOTIC-RESISTANT STAPHYLOCOCCIC.

LANCET. 1:446, 1950, Cairns, H. J. F., PENICILLIN-RESISTANT STAPHYLOCOCCIC.

SURG. GYNEC. AND OBSTET. 92:267-276, 1953, Melgney, et. al., CLINICAL SIGNIFICANCE OF INCREASING RESISTANCE OF ORGANISMS TO ANTIBIOTICS.

N. ENG. J. MED., 251:411-417, 1954, Howe, C. W., POST OPERATIVE INFECTIONS DUE TO S. AUREUS.

LANCET, 2:211-215, 1954, Clarke, S. K. R., et. al., CROSS-INFECTION WITH PENICILLIN-RESISTANT S. Aureus.

N. ENG. J. MED., 253:909-922, 1955, Findland, M., EMERGENCE OF ANTIBIOTIC-RESISTANT BACTERIA.

J. INF. DIS., 100:1-11, 1957, Sampolinsky, D., et. al., A SERIES OF POSTOPERATIVE INFECTIONS.

ANNALS NEW YORK ACADEMY OF SCIENCES, 65:65-66, 1956, McDermott, Walsh, THE PROBLEM OF STAPHYLCOCCAL INFECTIONS.

BACT. PROC. 57th, GEN. MEETING, DETROIT, MICH., April 28-May 2, 1957, Page 96-97, Cooper, M. L., et. al., ACUTE, SEVERE INFECTIONS IN YOUNG CHILDREN DUE TO MICROCOCCUS PYOGENES VARIETY AUREUS WITH A SPECIFIC BACTERIOPHAGE PATTERN.

BACT. PROC. 57th, GEN. MEETING, DETROIT, MICH., April 28-May 12, 1957, Page 97, Stinebring, Warren P., A STUDY OF A HOSPITAL OUTBREAK OF STAPHYLCOCCAL INFECTIONS II. PHAGE TYPING. AND VIRULENCE STUDIES.

HOSPITALS, June 16, 1957, 47, CONTROL OF STAPHYLCOCCAL AND OTHER INFECTIONS IN HOSPITALS.

VESTAL

INCORPORATED

4963 MANCHESTER AVE.
ST. LOUIS 10, MISSOURI

WEST COAST PLANT • MODESTO, CALIFORNIA

Aseptic Chain...NOW

It's admittedly difficult—but nonetheless necessary—to attack the new cross-infection problem. A return to an "old-fashioned" preventative program, assisted by modern sanitation products, is a proven solution to this problem. These aseptic procedures should include the entire hospital as well as surgical suites, nurseries and isolation areas.

Despite the efficiency of good air-conditioning equipment, a high percentage of pathogens, including drug-resistant staphylococcus, remain air-suspended in surgery and throughout other hospital areas. A majority of these pathogens settle on various surfaces—principally the floor. Unless destroyed, air movements redisperse them into the air.

Regular use of the clinically proven disinfectant, STAPHENE , or disinfectant-detergent VESPHENE , on floors and other exposed surfaces destroy these bacteria . . . greatly reduce cross-infection hazards.

STAPHENE and VESPHENE are all-purpose, non-selective phenolic disinfectants. They kill staphylococcus, enteric and respiratory pathogens and fungi even in the presence of organic matter . . . they destroy tubercle bacilli even in the presence of large masses of sputa.

The difference between STAPHENE and VESPHENE is in detergency. VESPHENE is capable of heavy soil removal as it disinfects. STAPHENE is a high concentrate disinfectant for use where light soil removal is required. A ½% dilution of STAPHENE (1:200) is sufficient for general disinfection. Both STAPHENE and VESPHENE are practically odorless. They are tailored to fit into any hospital sanitation program...*and with no more effort than normally employed for cleaning.*

The surgical wash is a vital link in the aseptic chain. The transmission of pathogens by the hands is too easily accomplished unless bacterial skin count is kept at a minimal level. SEPTISOL , the original hexachlorophene surgical soap, does this. The simplified SEPTISOL brushless scrub is a proven technique that gives optimum protection.

The incision area is another potential source of infection. Prepping the patient's skin with SEPTISOL is a clinically proven procedure.

A surgical soap of choice should have the capacity to free itself of bacterial contamination, if exposed. SEPTISOL has proven self sterilizing power.

SEPTISOL , STAPHENE , and VESPHENE are concentrates, making them economical in use dilutions. Each one is formulated to perform a specific task. They are products that will STRENGTHEN YOUR ASEPTIC CHAIN.

For additional information on how STAPHENE , SEPTISOL and VESPHENE can provide effective environmental sanitation for your hospital, consult your local Vestal representative or write to us on your letterhead.

VESTAL INCORPORATED
4963 MANCHESTER AVE.
ST. LOUIS 10, MISSOURI

WEST COAST PLANT • MODESTO, CALIFORNIA

pressure of preparing meals for hospital patients. It is imperative, however, that hospitals take extreme care in providing proper sanitary precautions. It is important because the hospital employee is naturally coming in contact with many more infected individuals in the course of his day's work than other food service employees.

Also, food in a hospital is usually transported through the building and is handled several times before it is served to the patient. If extreme care is not taken each time the food is handled, the chances of contamination increase proportionately.

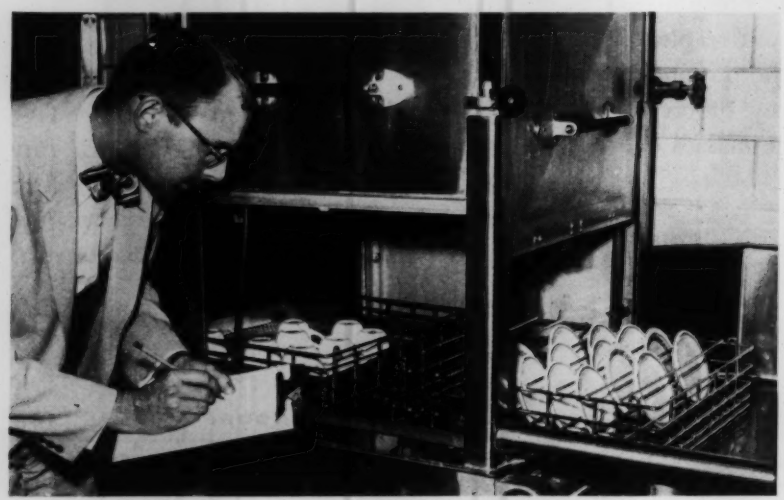
Finally, the patrons of the hospital food service, already the victims of the infectious process, tend to have a much lower resistance to bodily infections. Food infection, which might give little, if any, bodily discomfort to the average, well person, could be tragically significant to the person already ill. For these reasons, it is necessary to demand a higher standard of sanitation in hospital food service than elsewhere.

TRANSMISSION PROCESS

In order to understand what measures might be taken to protect patients, it is best first to examine briefly what is called the chain of disease transmission or the infectious process. For any disease to occur, there are six conditions that must be met. All of them must occur in a set and logical sequence. These six steps or links in the chain of disease transmissions are as follows:

1. Etiologic agent, i.e., the causative organism, pathogen, or infective agent or material.
2. Reservoir of infection or habitat that permits the survival of the etiologic agent.
3. Escape of the etiologic agent from the reservoir.
4. Transmission from the reservoir to the next prospective host.
5. Entry into the prospective host.
6. Susceptible host.

Too much emphasis cannot be given to the necessity for these six conditions to occur in proper order and in proper magnitude. The latter is especially important in food sanitation, because it is the infectious dose, or the number of organisms, rather than the bacterial contamination *per se*, which determines to a large extent whether outbreaks of food infection or food intoxication will occur. Fortunately, most of us can resist minor intoxications or infections. Our purpose in food sanitation is not to serve sterile food, but to serve food which has been sufficiently protected to prevent the build-up of enough bacteria or enough toxin to create an infectious dose for one of our patients.



INSPECTION of dishwashing and other equipment is an essential supervisory task in the hospital dietary department. The inspection should be done routinely and the findings recorded.

To protect the patient, a means of eliminating or modifying one of the links in the chain of disease transmission must be devised. This will disrupt the infectious process and prevent disease from occurring. Such precautionary measures should be taken with all food. Sanitation must be conducted on the premise that all food is contaminated, for it most surely will be at some point between production and consumption.

It is obvious that much of the burden of responsibility for such protection falls upon the dietitian. Too often, however, the dietitian is burdened with the *entire* responsibility and this is unfair. Food sanitation is a responsibility of, and must be shared by, top administration, and the housekeeping, nursing, engineering, purchasing, and dietary departments. Even the laboratories can and should play a role in quality control. These are the members of the team that must function together if food-borne disease is to be prevented in the hospital.

The aim is to eliminate or modify one of the links in the chain of disease transmission. What weapons, then, are available? The weapons or methods are these:

1. The purchase and proper storage of clean, wholesome, high quality food and drink.
2. Provision and maintenance of adequate food preparation and serving facilities.
3. Proper refrigeration, cooking, and food preparation techniques.
4. Properly protected transportation and service of food to patients.
5. Properly informed, healthy workers at every step in the food service operation.

PURCHASE AND STORAGE

The solution of this problem demands perfect working relationships between top administration, the dietitian, and the purchasing agent.

While the problem of establishing a reputable source of food supply is not difficult in the cities,

Patient care . . . or paperwork . . .

how does your dollar divide?

Often the promise of more and better *patient care* lies in the savings to be made on non-patient services.

Today, how much of *your* precious budget dollar is needlessly being spent on a multitude of clerical services that *could* be handled automatically, economically – with IBM punched cards?

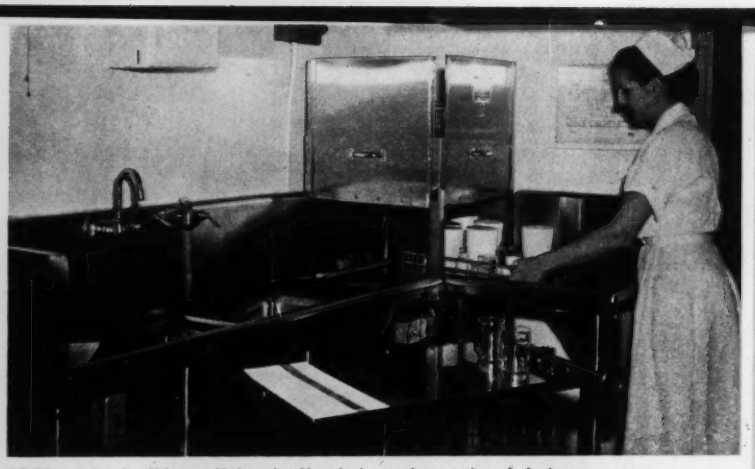
From patient billing to payroll, from medical records to materials control . . . moving swiftly from task to task, flexible IBM equipment serves *every one* of your 15 basic accounting and record-keeping services.

As a result, you cut the price tag markedly on clerical and business services . . . you develop less costly procedures . . . increase accounting efficiency . . . make *your* administration problems fewer and simpler.

Learn how a basic IBM installation can help you apply more of your budget dollar to vital patient services. Just call your local IBM representative or write to: HOSPITAL DEPARTMENT A57, International Business Machines Corporation, 590 Madison Avenue, New York 22, N. Y.

IBM DATA PROCESSING

DATA PROCESSING • ELECTRIC TYPEWRITERS
TIME EQUIPMENT • MILITARY PRODUCTS



FOOD service facilities at University Hospitals nursing stations help insure proper sterilization of patient food containers. Here a staff nurse uses a dishwasher.

administrators in small towns or communities will often have to use a local source of supply for such items as meat, milk, and perhaps many of the staple supplies.

Only pasteurized milk should be used in institutions. It is also desirable to use only meats which have been government inspected or locally inspected according to federal government specifications.

The administration or the purchasing agent should be cautious of food "bargains" without thorough consultation with the dietitian. Very often the increased rate of spoilage of foods obtained at bargain prices makes them more expensive than quality foods. Moreover, they may not fit into the planned dietetic program.

Having once purchased the best quality food available, consideration should be given to protecting it while it is in storage. The food should not be stored in areas which are exposed to hazards of leakage from broken sewerage and water pipes overhead, or exposed to flooding when floor drains in the area overflow due to sewage stoppage. Excessive heat, too, increases the rate of spoilage.

Although the demands for storage space are great, the administrator should take into account the infectious process when assigning space for food storage. He should give careful consideration to the dietitian when she requests refrigeration and freezer storage space. More and more foods are offered in refrigerated and fresh frozen forms, and due to ease of preparation, these are becoming very popular.

PREPARATION, SERVING FACILITIES

The administrator, purchasing agent, and dietitian must work together to provide the quality necessary in preparation and serving facilities. The housekeeping and engineering departments also must cooperate, because very often the proper repair and maintenance of this equipment depends upon them.

Food service is expensive and the most expensive aspect of it is the labor. To help cut the rise in labor costs, it is imperative that equipment be easy to clean and be installed in such a manner that cleaning is not hampered. Noncleanable equipment has great public health significance, because food prepared with unclean equipment will be grossly contaminated and thereby spread illness to many persons. When purchasing new equipment the bid information should require that any new equipment covered by National Sanitation Foundation standards carry the National Sanitation Foundation seal of approval. This practice will insure, as much as possible, that such equipment is of cleanable construction and will perform satisfactorily.

While the higher price of stainless steel and heavy commercial types of equipment is terrifying, it is generally true the increased number of years it is serviceable and ease of cleaning more than pay for the additional cost initially.

It is also important to consider the morale factor for the employee. When equipment is easy to clean and looks clean after it has been cleaned, a better job will be done by the employee for he likes to see the results of his labor.

The housekeeping and engineering departments play a most vital role in public health. This point can be best demonstrated by an emergency situation the author observed in a hospital kitchen. Just as the evening meal was to be served, a sewage stoppage occurred in a line from the building in which the kitchen was located. Since fixtures were being used on upper floors, the sewage began flowing out of the floor drains in the kitchen area and soon covered the floor with raw sewage. (The floor drains had been specifically placed in the kitchen in these areas to provide such protection for the sinks, dishwashing machine, and refrigerated areas to prevent pressure from building up and forcing sewage back into these appliances.)

The situation was soon complicated by the appearance of a plumber who, with hands dripping with raw sewage, began turning on various faucets and occasionally resting his hands on table tops and pieces of equipment. While faucet handles are not usually thought of as a likely source of disease organisms, the conditions created in this instance obviously had great public health potential. The employees were busy trying to portion and serve the evening meal in spite of the handicaps, and part-time student workers were just coming on the job to help them. They were unaware of what had transpired and of the potential danger of handling faucets and then handling food. It took quick work to adequately wash and disinfect the areas touched by the plumber before the serving operation could continue.

This incident points up the need for the housekeeping and engineering staffs' knowledge of the consequence of their actions.

RODENT, INSECT CONTROL

Maintenance might also include rodent and insect control. The best way to eliminate such intruders is tight construction and good housekeeping practices. Food

service and storage areas should be protected with adequate screening and construction. Poison bran or any of the residual type insecticides or rodenticides should not be used in food preparation or storage areas.

REFRIGERATION TECHNIQUES

Refrigeration is almost our only safeguard against the continued production of toxins by staphylococcal organisms. It is almost our sole safeguard against the infectious organisms which may have been introduced into food, such as salads or bland deserts, that are not subjected to cooking prior to service. Storage at temperatures of 40°F. or below will not kill organisms, but will prevent their growth. These temperatures completely prevent the build-up of toxins by the staphylococcal organisms, or in the case of infectious organisms, it prevents their growth into an infectious dose.

Refrigeration facilities in most food service operations are, unfortunately, very inadequate. The administrator must help the dietitian, both with funds and understanding, to provide more adequate facilities.

The dietitian, however, can, by using improved storage techniques, provide better protection. Putting white sauce and mayonnaise into a refrigerator in 40 gallon lots does not afford adequate protection. If the products go into the refrigerator at room temperature, it may be 24 hours before the inner core of the product has cooled to refrigeration temperature. During this time, bacterial growth is possible and food infection or intoxication probable. Food should be refrigerated in small quantities, such as in flat pans, so as to afford proper protection by cooling rapidly.

Frozen foods are becoming increasingly popular, and the use of these foods poses a public health problem. The normal protective cellular structure of most foods is broken down by the quick freezing process. After thawing, spoilage organisms can penetrate the food more easily. Fresh frozen foods do deteriorate more rapidly after thawing than fresh products do.

To preserve the quality of these foods and to prevent the build-up of infectious organisms, adequate refrigerator space must be provided. This is particularly necessary for meats, which should be thawed in the refrigerator prior to use.

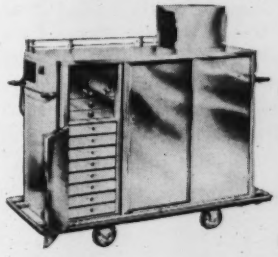
There is a tendency, on the part of kitchen personnel, to set bulky items, such as frozen turkeys and other meats, in the kitchen overnight to thaw at room temperature so that they are ready for use the next day. This allows the meat to remain at incubation temperatures for long periods of time, and the number of organisms in the meat increases rapidly.

An even worse practice is the immersing of the carcasses of turkeys or other fowl in water until thawed. The skin surface and interior of the bird have invariably been contaminated during evisceration. The water surrounding the bird soon becomes a "sewage soup", and allows the organisms to penetrate far into the muscle. The organisms are much more difficult to kill in such a location, and the normal cooking temperatures do not always kill them. These practices must be eliminated if food-borne outbreaks of salmonella infection or staphylococcal intoxications are to be avoided.

Cooking is also an effective weapon for killing organisms. Hot foods are very seldom associated with food infections, although cooking does not normally destroy the toxins that have been formed by staphylococcal growth in the foods prior to cooking. If foods, such as custards, are cooked immediately after preparation before the staphylococci have an opportunity to grow, and are then

A good hot breakfast, along with every other good meal, is one of the ways your hospital keeps its good reputation. The satisfied patient becomes a living walkie-talkie for your hospital.

Over 250 hospitals have, for the past few years, been proving the success of the Meals-on-Wheels System — a food service that delivers to the patient hot foods hot and cold foods cold—at a definite savings to the hospital in labor and food costs. For complete details write today to —



Meals-on-Wheels System

Dept. K.L., 5001 E. 59th St., Kansas City 30, Missouri

protected from further contamination until serving, intoxication can be effectively prevented.

Since dietitians are often appreciated for their ability to utilize "leftovers", it is interesting to note that normal cooking procedures do not always kill staphylococci in ground ham mixtures. This would indicate that ham mixtures must be kept refrigerated at all times when they are not being prepared or served.

TRANSPORTATION AND SERVICE

Transportation and service involve extensive handling of food and, therefore, must receive careful consideration as possible sources of food contamination. They are also important from another aspect. In many hospitals nursing personnel serve the food to the patient. Since the nurse has close contact with people who are ill and since she is a very likely source of infection, she should practice very stringent personal hygiene measures when handling food.

Nursing personnel are important from another aspect. Very often nurses administer supplemental feedings to patients during the day and night. Very often nursing personnel are responsible for the distribution of water to patients. If glasses are kept on the ward for these purposes, they should be subjected to the same sanitizing procedures as other food service utensils. Too often this is not the case.

If ice is used for cooling juices or water, it must be remembered that ice is drinking water and should be protected as carefully as the water itself. Very often this is not the case. Ice machines are often in the halls, completely unprotected, and easily accessible to anyone on the ward. Patients, nurses, and food service personnel use this ice for every purpose. The author has seen hospital personnel reach into the ice supply with their bare hands to get a few ice cubes for an individual glass of water.

These practices have a definite public health potential, since contamination of the ice means eventually contamination of some patient's glass of water. In effect, we are washing our hands in the patient's drinking water, a practice that would not be tolerated in the patient's room. Can we then tolerate it if it takes place back in the serving kitchen rather than in his room?

The administrator must assist the dietitian in setting up and enforcing adequate personnel policies for food service workers. The reservoir of infection for staphylococcal food intoxication is, as a rule, the food service worker. This is also true of the majority of other food-borne diseases. Although it has been pointed out that the source of contamination may be in the food supply, more commonly it originates with food service personnel.

In the past we have probably placed too much emphasis on the annual physical examination for each employee. While this is certainly desirable from the personal health viewpoint, this practice does very little to advance food sanitation. An annual examination gives fragmentary information on the food handler one day out of the year. It is not enough that the food handler be healthy on the particular day, but he must be healthy on every occasion that he is handling food. In hospitals we must work toward establishing personnel policies that permit the dietitian to remove any food handler who is overtly ill, or who gives a history of being so. This would include the food service employee with an infected hangnail or infected eye, as well as the one who is more acutely ill. If this measure is too drastic, the policy should be flexible enough so that the infected worker can at least be transferred from some duty, such as preparation of salads and desserts to a job not involving direct handling of food.

It is important that each employee understand the significance of improper refrigeration and poor personal hygiene. The continuing day-by-day supervision by the dietitian and administrator should point toward this goal. The management should insist on clean personal habits of its employees and have enough information to provide the "why" for sanitation policies.

TEACHING NEW EMPLOYEES

In determining work loads, it would be well to allow time to the dietitian and her staff to conduct a continuing inservice training program for old employees and a thorough indoctrination program for new employees. This last point is particularly important, for the new employee might just as well be taught to do things the right way. Such a program will render much better dividends than an occasional attempt at "food handler" training.

If these things are required of the employee, the management must provide the facilities which enable the employee to do his task easily and properly. Proper facilities should be provided near working areas to allow adequate cleaning, washing, and sanitization of the equipment the worker uses. Adequate handwashing lavatories also should be provided in convenient locations in the kitchen proper. If management has done its part by providing these facilities, it is in a much better position to require high standards of cleanliness from its employees.

In addition to the sources of help within the hospital, there are other sources that are not always adequately used. Local health department officials should be invited to assist in planning new food services, remodeling the old ones or for a periodic inspection of the day-by-day dietary operation from a sanitation viewpoint. State health departments also stand ready to help in specialized problems or for general reviews of food service operations. They are there to help protect your patients. I have stressed that food sanitation is a team problem and should be solved by a team approach in the hospital. The health department is one more member that should be added to that team. ■

Time-Tested Performance-Proved

POLAR WARE Stainless Steel

Clinical, sickroom and kitchen utensils

Pus Basins

No. S-8	8 1/8"	x 3 3/4" x 1 5/8"
No. S-10	9 7/8"	x 4 1/2" x 2 1/8"
No. S-12	12"	x 5 1/2" x 2 1/2"

Catheter Trays

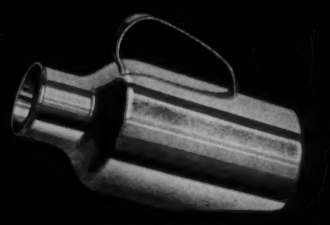
No. S-83	8 5/8"	x 3 1/4" x 1 3/8"
No. S-170	17 1/8"	x 4 1/4" x 2 1/4"

Dressing Jars

No. S-2	2 1/4 Qts.	5 1/2" x 6 1/2"
No. S-4	4 1/4 Qts.	7 1/4" x 7 3/4"
No. S-8	8 1/4 Qts.	8 1/2" x 9 5/8"

Wash Basins

No. S-30	3 1/2 Qts.	12 1/4" x 3 3/8"
No. S-32	4 1/2 Qts.	13 1/4" x 3 3/4"



Male Urinal

No. S-5 1 1/2 Qt. 4 1/4" x 5" x 9"

Solution Pitcher

No. S-020 2 Qts. 4 1/2" x 6 3/8"

Solution Bowls

No. S-134	7 Qts.	14" x 4 3/8"
No. S-136	9 Qts.	14 3/4" x 5"

Bed Pans

No. S-00	12 1/8"	x 9 3/4" x 3 3/8"
No. S-15	14"	x 11 1/2" x 4"

Sponge Bowls

No. S-75	24 ozs.	5" x 2 1/2"
No. S-106	40 ozs.	6 1/4" x 2 3/4"
No. S-107	64 ozs.	7 3/8" x 3 1/8"

Beverage Server

No. S-11 Hinged Cover
10 oz. 3" x 3"

Tumblers

No. S-7 7 ozs. 3"x3"

Irrigator

No. S-2 2 Qts. 5"x7"

Hospital personnel in a position to judge — nurses, doctors, pharmacists, dieticians — have learned by checking inventory records that Polar Ware utensils have those qualities of endurance that provide a bed-rock return on the investment they represent. Even more important is Polar Ware's professional reputation for features in design that best meet the needs of clinic, sickroom and kitchen.

In combination, these experiences explain why there is so strong a tendency among hospitals everywhere to standardize on Polar Ware — a wide, varied line only partially illustrated here. Leading supply houses from coast to coast carry Polar Ware. Ask the men who call on you, or write for the complete line catalog.

Polar Ware Co.

* 3500 LAKE SHORE ROAD
SHEBOYGAN, WISCONSIN

Merchandise Mart — Chicago 54 Room 1455
*123 S. Santa Fe Ave. Los Angeles 12, California
*415 Lexington Ave. New York 17, New York
Offices in Other Principal Cities
*Designates office and warehouse

purchasing

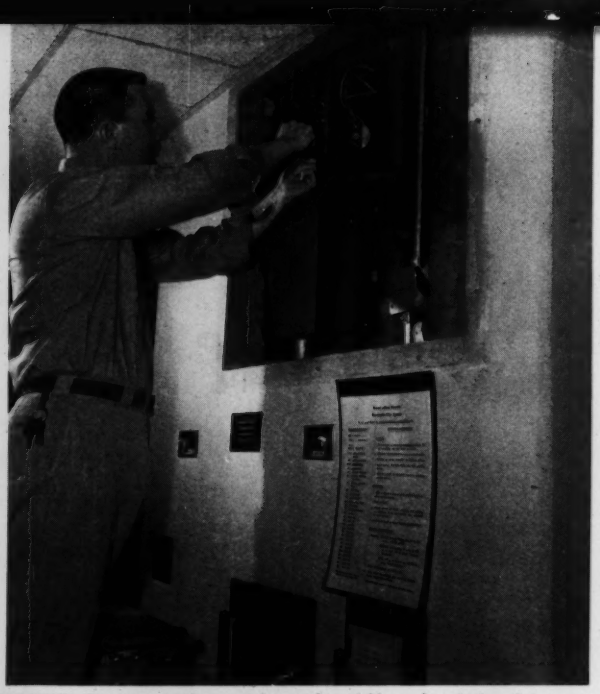
pneumatic and vertical conveyors

what are the contractor's obligations?

who should take charge of maintenance?

how should personnel training be handled?

by JOHN F. STOCKWELL



ABOVE: Because repairs must be made quickly, a hospital maintenance crew member should be trained in servicing pneumatic tube systems. Here an adjustment is made in a control box. LEFT: New members of the nursing staff receive instruction in operating the pneumatic tube system.

Advance planning is necessary to achieve smooth operation of a new pneumatic tube or vertical package conveyor installation, the author states. This article includes a suggested guide for relationship between the installing contractor and the hospital, along with observations on maintenance of the systems and training of those who will use them.

AUTOMATIC PNEUMATIC tube and vertical package conveyor systems are invaluable in a vertically planned building. Rhode Island Hospital is a good example: there are 11 floors with patients occupying the top 7.

With these systems, deliveries are accomplished quickly, since the tube takes about one minute and the conveyor approximately five minutes for the longest trip. This means that frequent deliveries are practical and, as a result, only a minimum of storage space is necessary on nursing units and in other departments that receive this service.

Also, elevator traffic is greatly reduced by the presence of this equipment. In a high building this is all-important, since delays for doctors, visitors and personnel are costly and are fertile ground for criticism.

However, it has been our experience that these advantages do not happen automatically when the equipment is installed. Unless there is quick, reliable maintenance and careful training of personnel who use the equipment, employees will not have confidence in it and will not use it.

We feel that much of our success in using this equipment is due to the preliminary planning that was done. We were able to anticipate most of the problems but found it wise to make only flexible plans in advance.

It was extremely helpful to have one person coordinate all internal operation affairs for this equipment, including relations with the contractor, maintenance and training. This began well before the equipment started to operate so that the hospital's mechanics could see the equipment under construction and could learn from the contractor's men.

CONTRACTOR RELATIONS

In order to insure adequate preoperation testing and quick maintenance service, we would recommend that an owner's relationship with the contractor be carefully planned, as follows:

1. A definite arrangement should be written into the specifications making the contractor fully responsible for maintenance for the first three months of operation. This provides expert maintenance during the period of most frequent breakdowns and helps to insure a good installation.

2. A procedure for requesting service during this three-month

John F. Stockwell is assistant to the director of Rhode Island Hospital, Providence.

now available!

SteriSharps®

the first sterile, stainless-steel surgical blade

new SteriSharps valuable aid to surgeons and nurses...saves time, eliminates blade waste

The new SteriSharps surgical blade is made of stainless steel. It has the sharpest, most uniform, most durable cutting edge available. Comes to you ultrasonically cleaned and heat-sterilized for asepsis. Saves time, simplifies technic.

Surgeons can depend on *consistent sharpness* with SteriSharps. Electronic testing by the ASR Sharpometer® guarantees uniform sharpness.

SteriSharps offer important economies, too. Only blades actually needed are used. They're unaffected by autoclaving, dry heat, solutions. Sealed packets can be re-autoclaved, stored indefinitely. For details, write: ASR Hospital Division, Dept. HH, 380 Madison Ave., N. Y. 17, N. Y.

Blade Dispenser available. Your supplier has SteriSharps surgical blades in every design. Stainless-steel dispenser shown above is yours free with every five gross.

Only SteriSharps offer all these advantages . . .

- Sharpest, most durable cutting edge
- Consistent sharpness in every blade
- SteriSharps will not corrode
- Can be re-autoclaved, stored in packs
- Sterile SteriSharps eliminate jars, racks and irritating solutions

A·S·R precision products

SteriSharps . . . the first sterile, stainless-steel surgical blade

period should be agreed upon. Specifically, a commitment in writing should be obtained stating how soon a mechanic can arrive at the hospital after a request has been made. A 24-hour maximum would be reasonable. For example, our contractor took his tube mechanic away from the hospital after the system had operated successfully for a few days. Shortly thereafter, we had a blockage that staff men couldn't repair. We called the district salesman, as instructed, but it took 20 hours to locate him and nearly two days elapsed before a repairman arrived at the hospital.

3. The equipment should not be placed in operation until some responsible member of the hospital organization has thoroughly tested it and is satisfied. Tests by the contractor are apt to be too quick and too limited.

4. One responsible member of the hospital organization should be given the job of coordinating between the contractor and the hospital on all affairs. He should plan to give this work very close attention. Unless this is done, each of the contractor's mechanics and executives may tell important things to many people and nobody will have the whole correct story.

5. Hospital staff members should be used to train personnel individually. The contractor's personnel should be used to train the hospital's coordinator and trainers. The contractor will probably send a sales representative to carry out this training, and he is interested only in explaining how the system works and how good it is.

6. An agreement should be made that the contractor's personnel will neither educate nor give answers to hospital employees in general, but will only work with the coordinator and maintenance men. We decided that no supplies were to be piled above the top of the package conveyor baskets (10 inches total height) although a total height of 18 inches would fit, physically, through the space traveled. When personnel asked the contractor's mechanics about this, he told them 18 inches, so we had to re-train people on this point.

7. An internal procedure for making repairs should be set up and enforced. Several blockages in our pneumatic tube system occurred because people who didn't know it wasn't working sent carriers. We have it announced over the public address system when the automatic equipment should not be used and when it is usable again. Departments that cannot hear this announcement are telephoned. This is satisfactory, especially if announcements are repeated, but an automatic signaling device at sending stations would be better.

8. Conferences should be held with responsible executives of the contractor at least once a month for three or four months after installation. This enables the hospital to get action when local representatives are slow.

MAINTENANCE

The necessity for quick service on repair jobs makes it necessary to use hospital staff members to maintain this equipment rather than to rely on a service contractor. A good plan is to have at least one maintenance man specially trained in this equipment on duty at all times when the equipment is in operation. In addition, there should be at least two other men on duty who have been oriented enough so that they can help out during emergencies. This is especially important during the first few months of operation.

It is advisable to use a report form for every breakdown, since the specifications may make the hospital pay for parts and/or labor which are necessary for repairs caused by personnel errors. It will be helpful to know where the training program may be inadequate. The form should include the exact location, nature and cause, specifying whether the breakdown is due to mechanical or electrical failure, or to personnel error. It probably will need to be rendered to the coordinator daily during the first few months of operation.

AUTOMATIC EQUIPMENT REPORT
9/10/57

PNEUMATIC TUBE

Changed two (2) brushes in No. 4 line selector and No. 2 line selector one (1) brush. System operating normally. No breakdowns. Making gaskets for covers for screen clean out openings. Cleared clogged up "F" line—carrier not properly fastened.

TRAYVEYOR

Operating normally. No breakdowns. Cleaned out pit in main kitchen.

PACKAGE CONVEYOR

Out of service from 1:20 to 1:55 p.m., due to a loose screw holding LS-1 open at loading station at the seventh floor. Repaired same. Cleaned out pit in main kitchen.

AUTOMATIC equipment report at Rhode Island Hospital gives details of servicing operations and nature and duration of any breakdown.

PERSONNEL TRAINING

We were advised at one nearby hospital that after eight years of experience with a tube system they had decided it was better to put as many carriers into service as necessary rather than enforce a rule of returning a received carrier immediately to its home station.

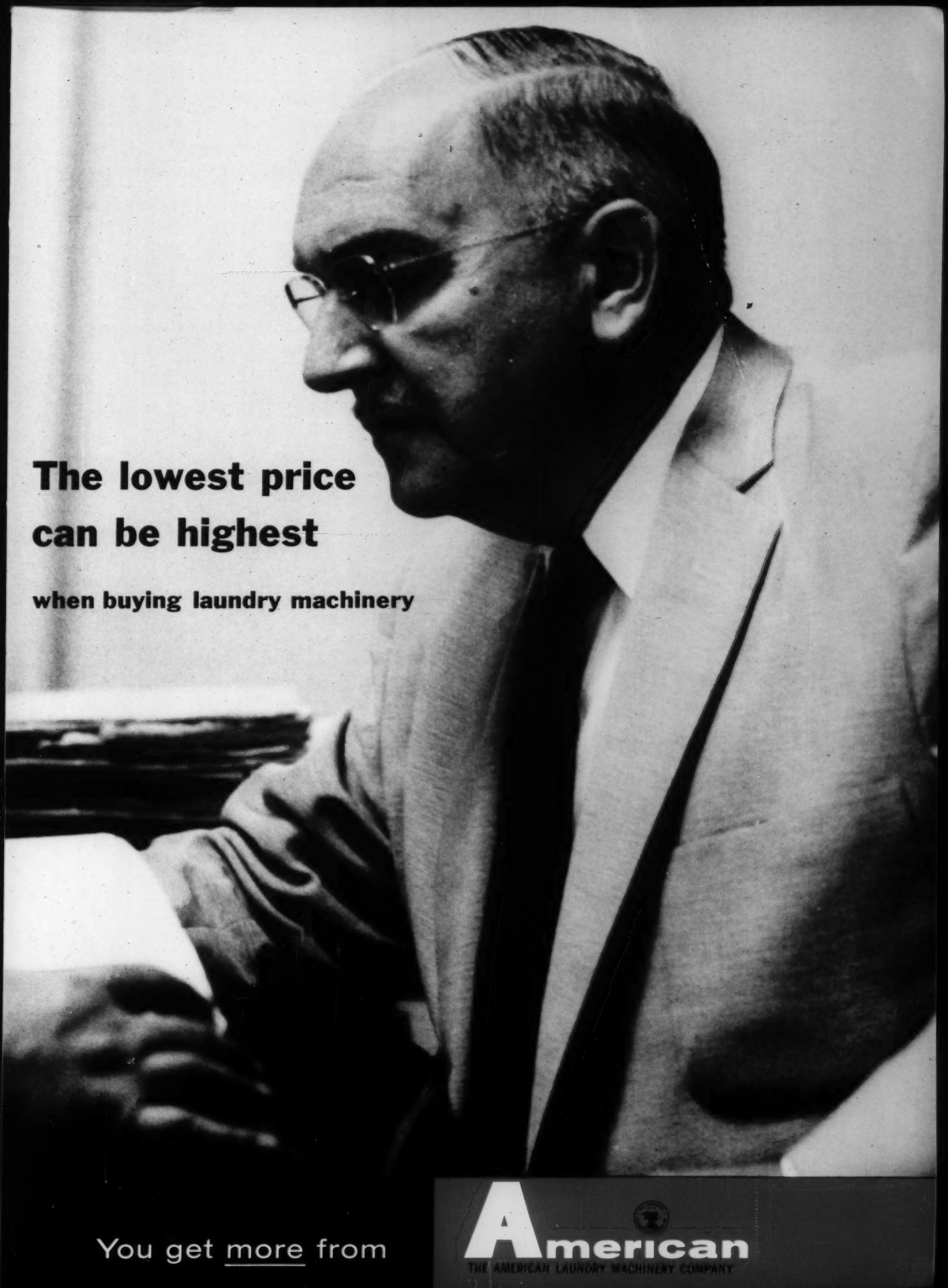
At a price of $60 per tube carrier we disagreed. Also, as a result of the interruption of service and demoralizing effect caused by breakdowns, we decided not only to train people who would use this type of equipment, but also to require that every person using the equipment be given a card certifying that he has been trained by a qualified trainer. Training is still being done regularly by the personnel department for all new employees.

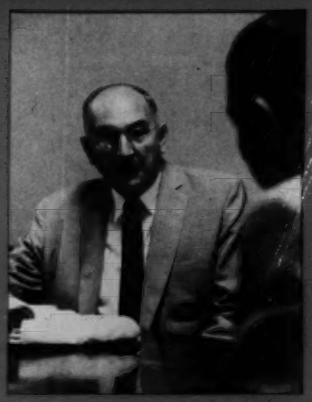
After 23 months of operation we find that tube carriers are still being returned quickly. We attribute most of the successful, smooth operation of this equipment to good maintenance and continuous training by a *central* department.

GENERAL OBSERVATIONS

We have found that three tube carriers and two conveyor baskets are adequate for each nursing unit (average is 32 beds per unit). More of one or the other are needed by other departments such as central services, pharmacy, stores, laboratory, medical records and mail room.

It is helpful if the stations have the same letter-numeral combinations as the unit or department at which they are located. For example, on the package conveyor, the dial is set for 5-B to send to Unit 5B. ■


The lowest price
can be highest
when buying laundry machinery
You get more from
American
THE AMERICAN LAUNDRY MACHINERY COMPANY



All too often lower price is lower value

Price is one of the most important factors in making a buying decision. However, just as important as the price itself are the many factors that determine price:

Will the manufacturer be in business next year? Twenty years from now?

Will the manufacturer provide survey engineering and planning service?

Is the machinery right for your particular operation, or is it too large or too small?

Are you sure it is the latest and best machinery of its kind?

Are the terms most advantageous for *you?*

Who will hold the note—the machinery *manufacturer,* or some stranger?

Will you get help in installing the machinery and in training your employees in its operation?

Does the manufacturer provide field engineering service?

Does the manufacturer furnish service and instruction manuals?

Can you get repair parts quickly if necessary?

What will be the useful life of the machine? What will be its trade-in value?

We invite you to tear out this page and ask these questions of your American Man from the Factory before you buy any laundry machinery.

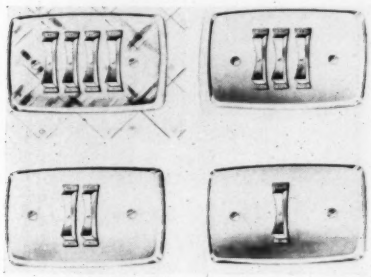
You get more from

American

The American Laundry Machinery Company, Cincinnati 12, Ohio

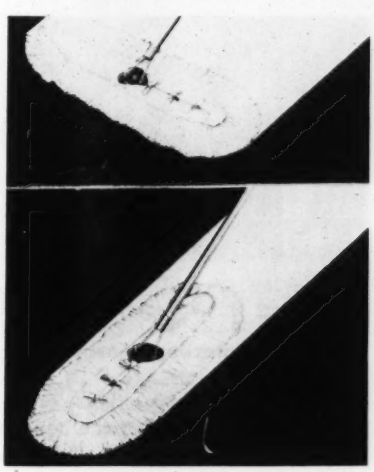
equipment and supply review

Phosphorescent switches (22B-1)
Manufacturer's description: Made of phosphorescent material, this switch emits a soft velvety glow



which pinpoints the location of the switch even in a completely darkened room. The silent switches are available in combinations of one to four switches on a standard size wall plate as well as on an eight-position master control. *Pyramid Instrument Corp., Dept. H, Lynbrook, N.Y.*

Two-way dust mop (22B-2)
Manufacturer's description: This two-way dust mop has an automatic spring fastener that locks the handle in the metal frame so that either a wide or a narrow dusting surface is available for whichever work is required. The dusting head is always flat on the surface, providing a maximum of dusting efficiency. The mop is made of long staple 4-ply cotton yarn. The canvas cover to which this cotton is sewed has been sanforized for ease of fitting. The handle is made of hard maple and has a natural finish. *Tu-Way Products Co., Dept. H, 1423 Franklin St., Detroit 7, Mich.*



Self-powered food conveyor (22B-3)
Manufacturer's description: This stainless steel food conveyor has an integral battery-powered motor that drives a fully loaded conveyor, weighing 600 lbs., at approximately 2 miles per hour forward and ½ mile per hour in reverse. A fully loaded conveyor will move up or down a rise of one foot in 20 feet under complete control. It is designed to maneuver and fit easily into all standard elevators. The caster arrangement permits a complete turn within a 78-inch circle. The conveyor has a variable capacity of from 18 to 24 meals and contains separate heated and refrigerated compartments. As the unit is being preheated or precooled, a built-in recharger operates automatically to charge the standard 12-volt automotive battery that powers the unit. *S. Blickman, Inc., Dept. H, 536 Gregory Ave., Weehawken, N.J.*

New hospital bed (22B-4)
Manufacturer's description: Designed to rigid government specifications in conjunction with a nationally known research foundation, this new bed comes in either hand or motor operated models. The ad-

An endeavor is made to screen carefully the products appearing in this section. However, the statements printed have been made by the manufacturer and are brought to your attention primarily to keep you informed of new developments in the field. —The Editors.

If you wish to have your name sent direct to the manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 18 E. Division St., Chicago 10, Ill.

PRODUCT NEWS

- ____ Phosphorescent switches (22B-1)
- ____ Two-way dust mop (22B-2)
- ____ Self-powered food conveyor (22B-3)
- ____ New hospital bed (22B-4)
- ____ Reach-in refrigerators (22B-5)
- ____ Side arm traction frame (22B-6)
- ____ Portable photocopy machine (22B-7)
- ____ Electronic oxygen analyzer (22B-8)
- ____ Disposable plastic hot cup (22B-9)
- ____ Cigar and cigarette receptacle (22B-10)
- ____ Time recorder (22B-11)
- ____ Patient room wardrobes (22B-12)

PRODUCT LITERATURE

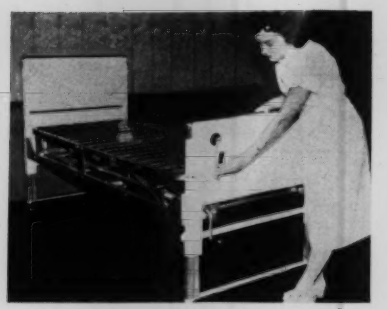
- ____ Vinyl metal laminated wall panels (22BL-1)
- ____ Standby generators (22BL-2)
- ____ Open shelf filing unit (22BL-3)
- ____ Curtain wall panels (22BL-4)
- ____ Electronics parts and equipment (22BL-5)
- ____ Furniture (22BL-6)
- ____ Standpipe and hose systems (22BL-7)
- ____ Vat dyeing fabrics (22BL-8)

NAME and TITLE _____

HOSPITAL _____

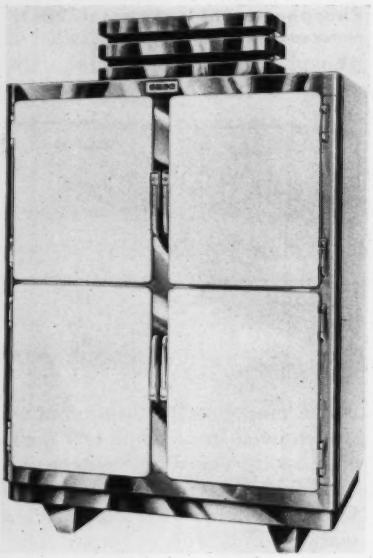
ADDRESS _____

(Please type or print in pencil)



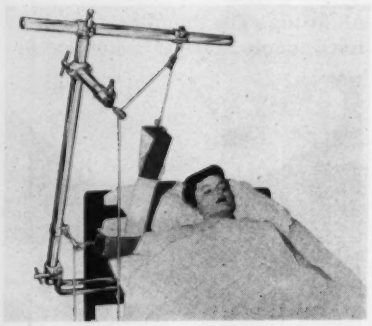
justment crank returns the bed automatically to level position from any special therapeutic position without further adjustments or eye leveling by operator. The crank then folds compactly into the handle casing at the foot of the bed. Twin telescoped legs provide easy action in raising and lowering the bed, even when occupied by a heavy patient. *Harris Hub Co., Inc., Dept. H, Merchandise Mart Plaza, Chicago 54, Ill.*

Reach-in refrigerators (22B-5)
Manufacturer's description: This new line of reach-in refrigerators (Series M A) will feature a condensed cabinet, only 26 in. deep to permit installation in limited access areas. There are both 4-door and 6-door models. Net capacities are 32 and 50 cu. ft. The refrigerators are available with either solid



or glass doors. *Koch Refrigerators, Inc., Dept. H, 401 Funston Road, Kansas City, Kan.*

Side arm traction frame (22B-6)
Manufacturer's description: The new device may be attached at any point along the side of the frame, even on the sections that may be elevated. This assembly eliminates the need for keeping the patient in a stationary position while in traction. When the back rest is raised or lowered, for example, the traction remains unchanged. The frame may also be attached to the end of the bed for traction



on the leg or foot. *Zimmer Mfg. Co., Dept. H, Warsaw, Ind.*

Portable photocopy machine (22B-7)
Manufacturer's description: This briefcase size photocopy machine can be carried from office to office, re-

VASELINE® PETROLATUM GAUZE

conforms fully to the official standards prescribed by the U.S.P.

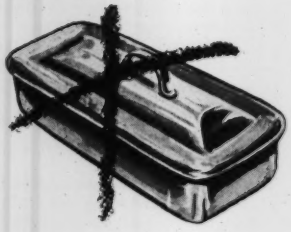
This prepacked, pretested material assures unquestionable sterility at time of use.

Especially-designed equipment impregnates the gauze so lightly and uniformly that the danger of maceration is minimized.

Most hospitals are neither staffed nor equipped to follow the U.S.P. XV specifications for the preparation and control testing of a dependably sterile petrolatum gauze. That is why 'Vaseline' Sterile Petrolatum Gauze U.S.P. is their choice of a nonadherent dressing. It has proved itself "best by test" in millions of cases in thousands of civilian as well as military hospitals throughout the United States.

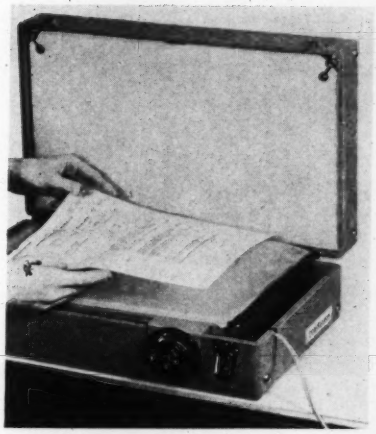
WHY USE SUBSTANDARD MATERIAL

when this superior prepacked sterile product is available at a worthwhile saving?



CHESEBROUGH-POND'S INC.
Professional Products Division
NEW YORK 17, N.Y.

VASELINE is a registered trademark of Chesebrough-Pond's Inc.



quires no special skill to operate, is unaffected by normal office lighting and uses the same setting for all material. The machine will produce negative film in eight seconds for offset printing plates. It copies all colored inks, crayon, pencil, and even spirit duplicator and ball-point pen impressions. *F. G. Ludwig Co., Inc., Dept. H, 103 Coulter St., Old Saybrook, Conn.*

Electronic oxygen analyzer (22B-8)

Manufacturer's description: This lightweight, battery-operated oxygen

analyzer enables inexperienced personnel to obtain accurate readings within 30 seconds. Should the need arise, the analyzer can be recalibrated within a few minutes. The unit is activated with a 4½-volt portable radio A battery that provides enough energy for approximately 5000 tests. The analyzer permits frequent routine checking to determine whether oxygen concentrations are maintained. *O.E.M. Corporation, Dept. H, Fitch St., East Norwalk, Conn.*

Disposable plastic hot cup (22B-9)

Manufacturer's description: Priced to compete with paper cups, this throw-away all-plastic hot cup holds seven full ounces of liquid and has a folding handle which locks in slip-proof grooves. No heat is transmitted to the handle or lip of the cup. The special heat-resistant plastic is suitable for hot beverages, soup, chili, stew, in addition to medicinal application. *Federal Tool Corporation, Dept. H, 3600 W. Pratt Blvd., Chicago, Ill.*

Cigar and cigarette receptacle (22B-10)

Manufacturer's description: This wall-type sand urn can be furnished in stainless steel or bronze, in satin

1907 ▼ 50 Years of Service to Physicians, Hospitals and Allied Institutions ▼ 1957

To GAIN Accreditation... and KEEP IT

Don't Overlook our Medical Staff Minute Book... Medical Staff Bylaws... and the Questionnaire and Survey Report

The MEDICAL STAFF MINUTE BOOK has forms for all of the essential data required by the Joint Commission on Accreditation of Hospitals. A complete staff minute book contains 18 different forms, 240 assorted sheets.
For samples of these forms request Sample Group No. 52.

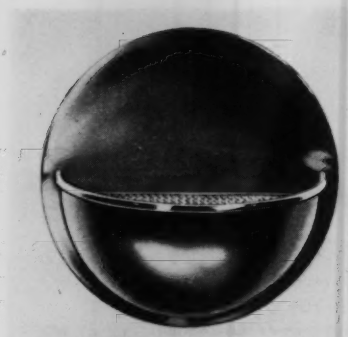
▼

The MEDICAL STAFF BYLAWS conform to the "Principles of Establishing Bylaws, Rules and Regulations of the Medical Staff of a Hospital" issued by the Joint Commission on Accreditation of Hospitals. These model bylaws are available in booklets for four different types and sizes of hospitals. Write for further information.

▼

The QUESTIONNAIRE AND SURVEY REPORT, Form A-603, comprises forms similar to those used in evaluating the departments of a hospital for accreditation by the Joint Commission on Accreditation of Hospitals. This is an excellent tool for periodically reviewing your entire hospital operation. We will send you further information on request.

Physicians' Record Company
161 W. Harrison Street ▼ Chicago 5, Illinois



finish. The receptacle is a ½-sphere attached to the lower half of a 12½-in. diameter back plate which is flanged to 5/16-in. depth, giving added strength and beauty. The screen is attached to the top rim of the bowl, and can be easily lifted out for the removal of any refuse. The complete urn when filled with sand weighs approximately seven pounds. *Witte Building Specialties, Inc., Dept. H, 1003 Donovan Bldg., Detroit 1, Mich.*

Time recorder (22B-11)

Manufacturer's description: This combination job cost and payroll recorder helps guard against violations of the federal wage-hour law. It provides accurate, indisputable records of wages paid for hours worked as required by this statute. The new time recorder is housed in a compact, sturdy metal case and operates from any desk top. It can be wall-mounted if desired. It is available with synchronous motor drive for AC circuits or for a master clock operation. *The Cincinnati Time Re-*

corder Co., Dept. H, 1733 Central Ave., Cincinnati 14, Ohio.

Patient room wardrobes (22B-12)

Manufacturer's description: This wardrobe is made up of several standardized units which, when combined, adequately fill patient room needs. The wardrobe shown uses a full length clothes storage unit on one side of the lavatory unit and another similar unit, but with a shoe drawer, on the other side. The center unit has storage drawers and a back panel with mirror and fluorescent light. These patient room wardrobes move in like furniture, free-standing or recessed. *Maysteel Products, Inc., Dept. H, 740 N. Plankinton Ave., Milwaukee 3, Wis.*

Insulated Bedside Water Server

Saves many trips for busy nurses! Pleases patients, too! Keeps water, juice, other beverages cold up to FOUR hours — even overnight if ice is added. Keeps coffee, tea, broth, etc. HOT for hours.

Lightweight; easy for patients to handle—yet unaffected by daily knocks and abuse. Made of the strongest plastic known. Double wall insulation. Two-tone design — choice of pastel green, yellow or copper-tone body with black top, bottom and handle. Can be sterilized at temperatures up to 190°—can be washed in your dishwasher.

ONLY **825** EACH
In dozen Lots

Ask your DON salesman to show you this insulated Bedside Server—just one of 50,000 time- and work-saving items sold by DON! As with everything you buy from DON, Satisfaction Guaranteed or your money back.

EDWARD DON & COMPANY
GENERAL HEADQUARTERS—2201 S. LaSalle St.—Chicago 16, Ill.
Branches in MIAMI • MINNEAPOLIS-ST. PAUL • PHILADELPHIA-CAMDEN

THIS MONTH'S *Super Value*

BUILT OF FINEST BIRCH HARD-WOOD

It's a Great space saving 2-in-1 unit!

#1068½ CHEST DESK

This four-drawer chest-desk requires only 35" x 19" floor space. When its drop-leaf shelf is raised it looks like a drawer front. The shelf and the four drawers (2 large, 2 small) have recessed pulls. Top of chest is covered with grained plastic and has protective plastic edging. When order is sufficient, any finish can be supplied.

SEND FOR BULLETIN 1029

EICHENLAUBS
Contract Furniture
3501 BUTLER ST., PITTSBURGH 1, PA.
ESTABLISHED 1873

E-21

product literature

(SEE COUPON, PAGE 93)

Vinyl metal laminated wall panels (22BL-1)—Wall panels of decorative vinyl plastic material bonded permanently to aluminum or steel sheet are described in this 8-page brochure. The panels combine the texture, color and design available in the unlimited field of plastics with the functional strength and workability of metal to provide an interior wall finish material that resists abuse and abrasion while actually protecting walls against severe impact. *Clad-Rex Corp., Dept. H, 2101 Indiana Ave., Chicago 16, Ill.*

Standby generators (22BL-2)—Two folders available—one describing installation procedure for standby generators and the other describing a standby or auxiliary power plant for use in connection with equipment which cannot tolerate any interruption of electrical power. *United States Motors Corp., Dept. H, Oshkosh, Wis.*

Open shelf filing unit (22BL-3)—This new brochure outlines the advantages of an open shelf filing unit that saves almost 60 per cent in floor space at one-third the equipment cost. The cabinet-type unit is available with several variations and can be adapted to meet particular needs. *Deluxe Metal Furniture Co., Dept. H, Warren, Pa.*

Curtain wall panels (22BL-4)—Insulated porcelain enamel panels for curtain walls is the subject of this 20-page manual. Following a review of the development of the curtain wall method of construction in general, a detailed discussion of various curtain wall components is presented. *The Erie Enameling Co., Dept. H, Erie, Pa.*

Electronic parts and equipment (22BL-5)—A 404-page catalogue of electronic parts and equipment that lists more than 27,000 items. *Allied Radio Corporation, Dept. H, 100 N. Western Ave., Chicago 80, Ill.*

Furniture (22BL-6)—In full color, this eight-page brochure illustrates a line of institutional furniture. Described are tables, chairs, and storage cabinets. *Brunswick, Contract Furniture, Dept. H, 623 S. Wabash Ave., Chicago 5, Ill.*

Standpipe and hose systems (22BL-7)—A new safety code covering "Inspection, maintenance and protection of standpipe and inside hose systems" is available without cost. This new code reviews the various services performed by a standpipe and inside hose system. Specific guidance is provided for periodic inspection of all components in the system. Instructions for maintenance of hose, couplings, nozzles, and playpipes, are concise. *Fire Equipment Manufacturers' Association, Inc., Dept. H, One Gateway Center, Pittsburgh 22, Pa.*

Vat dyeing fabrics (22BL-8)—A new low-cost method of vat dyeing fabrics on your own premises, using your own laundry equipment, is described in this four-page folder. *American Aniline Products, Dept. H, Koppers Bldg., Pittsburgh 19, Pa.*

County Newspaper Praises Professional Fund-Raising Counsel

Ingham County News editorial sums up Ketchum, Inc. service

Excerpts from the *Ingham County News* Editorial Page, June 20, 1957:

"Before the campaign was launched the hospital board spent much time considering professional counsel. It was finally decided that in the light of 2 previous attempts at fund-raising for hospitals, professional advice and direction were needed. Ketchum, Inc., of Pittsburgh was engaged.

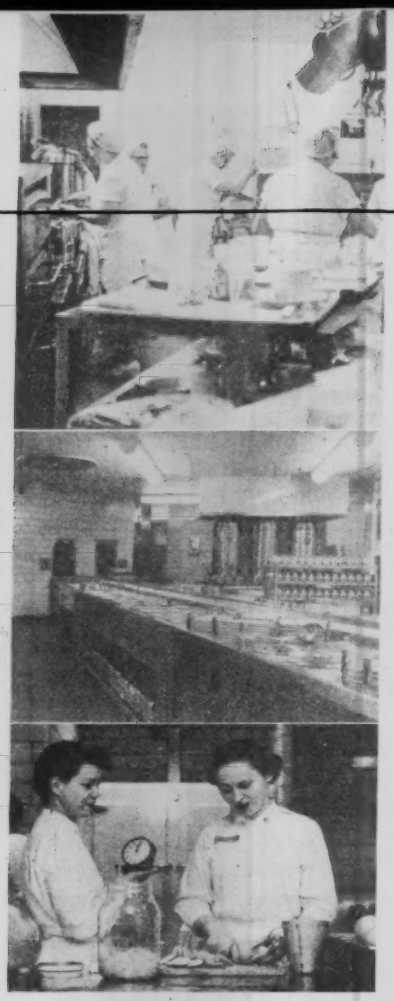
"After sizing up the situation, Ketchum, Inc., sent three of its best men to Mason. They studied community resources. They matched them with hospital needs. They built up categories of prospects. They enlisted men and women volunteers. They trained canvassers. They prepared educational material to sell the hospital idea. They worked hard. They gave advice which proved invaluable. They kept the organization clicking. They were instrumental in helping this community achieve success in an undertaking that three months ago was called unrealistic. They helped local people to help themselves . . .

"This community needed professional help in its hospital campaign. What was paid Ketchum, Inc., for that professional help should prove to be the soundest investment this community has ever made."

MASON HOSPITAL
MASON, MICHIGAN
Goal: $500,000
Raised: $533,430

MEMBER THE AMERICAN ASSOCIATION OF FUND-RAISING COUNCIL A HALLMARK OF ETHICAL FUND-RAISING

KETCHUM, INC.
Campaign Direction • Public Relations
CHAMBER OF COMMERCE BUILDING
PITTSBURGH 19, PA.
500 FIFTH AVENUE, NEW YORK 36, NEW YORK
JOHNSTON BUILDING, CHARLOTTE 2, NORTH CAROLINA



what's new in food service?

APPROXIMATELY 2800 dietitians, nutritionists, home economists and guests set aside the beaches and deep sea fishing of Florida during business hours late last month to seek new ways to improve food service to patients. Here—in question and answer form—are some of the new pieces of equipment and the new techniques and tools for improved food preparation and dietary administration reported at the 40th annual meeting of the American Dietetic Association in Miami, Fla.

What's new in demographic and social patterns that would influence the dietitian's role in the hospital and the community?

1. The increased birth rate, lower infant mortality and the increased numbers of teen-agers who live to go through college point up the need for more nutrition education in our schools. There are many more persons in the golden age group, many of whom will be in need of hospital services, including nutrition instruction as inpatients and outpatients.

There is an increase in the number and scope of private agencies with a great need for coordination of activities and joint planning among all agencies in the communities.—GORDON W. BLACKWELL, PH.D., *chancellor, Woman's College of the University of North Carolina, Greensboro.*

2. Our society places such high value on conformity that creativity is discouraged. The stereotype, the habit, the unchanged and unwritten policy, the desire not to stand out from the crowd, the reluctance to communicate in anything but well worn cliches—all of these are limiting forces which prevent us from coping with the state of constant change we live in. This is true in the military, in industry, and in household as well as institutional kitchens. If we could take as our motto, "nothing necessarily has to be the way it is", for even a few minutes a day, we might break the spell of unimaginative routine.—FRANCIS A. CARTIER, PH.D., *educational specialist and associate professor of communication, Air University, Maxwell Air Force Base, Ala.*

What new developments in food technology will make the dietitian's task easier, more efficient and less costly?

1. New food products and processes with a tremendous potential for the hospital kitchen include precooked dehydrated foods, such as chili and beans, chicken and rice, and spaghetti with meat sauce. Dehydro-freezing, where water is taken out of the product prior to freezing, is currently limited to apricots, peas, carrots, and apples. Use of irradiation for pasteurization and sterilization of products will curb molding of citrus fruits and knurling of potatoes as well as extension of shelf life for carrots, peaches, peas, cured ham, chicken, and pork chops.—JANE C. EBBS, *special feeding and nutrition advisor, Department of the Army, Office of the Quartermaster General, Washington, D. C.*

2. Good food prepared properly and frozen at low temperatures and held there at uniform temperature will alleviate even more of our problems in preparing diets for patients. Unfortunately the present "rocky road of distribution" for frozen foods rather than a uniform system of time-temperature from farm to patient bedside has resulted in much frozen food spoilage. It should be remembered that each 5° variation in the temperature range from 0°-30°F. speeds up the change in the product three or four-fold.—FLOYD DEEDS, PH.D., *head, pharmacology section, Western Utilization Research and Development Division, Agricultural Research Service, U. S. Department of Agriculture, Albany, Calif.*

MORE FOOD FEATURES

New officers of the American Dietetic Association and the award recipients are on p. 18.

Article on controlling food-borne disease in the hospital is on p. 80.

What new preparation techniques and tools have been introduced that will make hospital food better and safer for patients?

1. Dried prunes that do not need soaking and are cooked at low temperature, refrigerated iced tea that is made by pouring cold water over the tea, and the addition of cinnamon to chocolate cake, nutmeg to creamed chicken and thyme to cooked vegetables are some of

best from every angle

bends to any angle
for use in hot and cold liquids
disposable... paper based
safe... sanitary
no danger of breakage or contagion
original cost the only cost

the drinking tube that has everything

refer to
HOSPITAL PURCHASING FILE
for listing and prices

CANADIAN DISTRIBUTORS
INGRAM & BELL LTD.
HEADQUARTERS: TORONTO

FLEX-STRAW CO.
2040 BROADWAY
SANTA MONICA, CALIF.

please send samples and literature.

Name.....
Hospital.....
Address.....
City.....State.....

the newer food preparation techniques that can improve the style, form and flavor of hospital food. —PEARL JANSSEN, *associate professor of home economics, University of Illinois, Urbana.*

2. Additional techniques and tools for improving food preparation in hospitals are standardized recipes, including ones for meats; proper thawing of frozen foods; immediate service of broiled foods and green vegetables; and the tasting of foods for flavor, doneness and consistency by the dietitian. —MARGARET L. MITCHELL, *vice president—food production, Stouffer Corporation, Cleveland.*

3. Since salmonella, one of the chief causes of food-borne disease, is more prevalent in sprayed whole eggs, frozen egg yolks, and frozen egg whites, broken egg products should only be used for products that will be heated to a 350°F. inside temperature for 30 minutes. Therefore, frozen egg yolks and egg whites should not be used for egg nogs and scrambled eggs.—NORMAN B. MCCULLOUGH, M.D., *chief, laboratory of clinical investigation, National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda, Md.*

What new pieces of equipment are available to hospitals to improve food preparation and service?

1. Potato peelers with mechanical lifts and dial-type scales, mechanical tenderizers, machine washer for green vegetables, small tilting steam-jacketed kettle, steam kettles with refrigerator coils that will permit cooking and refrigeration in the same container, portable electric booster on steam kettle for deep fat frying, skate wheels for transporting items in the kitchen, and temperature timers on the outside of the oven that record the internal temperature are some of the new pieces of equipment designed for the hospital kitchen. — ARTHUR C. AVERY, *technical director, commissary research division, Navy Supply Depot, Bayonne, N. J.*

2. Food service equipment of the future includes a pot and pan washer under the pot and pan sink, portion-planned refrigerator, speed cooker with deep freeze unit below, throw-away plastic dishes, portable pot and pan washing bin adjacent to range, and a speed range. — CLARICE D. GULLICKSON, *professor, hotel and institution administration, College of Home Economics, Pennsylvania State University, University Park, Pa.*

With the increased emphasis on the care of the mentally ill, what steps have been taken to insure quality food service in mental hospitals?

In its hospital inspection program the American Psychiatric Association considers the dietary department one of the 13 essential areas of service. Distribution of points in the rating of the dietary department is as follows: personnel, 30 points, location of department, 10; space, 10; equipment, 16; diet and service, 20; good housekeeping and maintenance, 4, and records and reports, 10.

Specific recommendations in each of the above facets of dietary operation call for:

- Director of dietary department should be a member of the American Dietetic Association and a good administrator. She must report to the superintendent, assistant superintendent or superintendent-medical.
- Tray distribution should be a dietary function with dietary personnel delivering the trays to the patient.
- There should be an inservice training program of at least one class hour per week.
- Employee food service preferably should be handled by a canteen or concession.
- Menus should be written at least one week in advance of use, preferably two weeks.
- China or plastic dishes, a napkin, and a full set of tableware should be available for all mentally ill patients. Only metal trays and paper dishes should be used for the most extreme cases.—CHARLES K. BUSH, M.D., *chief inspector, central inspection board, American Psychiatric Association, Washington, D. C.*

What new management techniques are being used that will make it possible for dietitians to run a more efficient and more economical operation at the same time giving more and better care to patients?

1. System of program evaluation used by the Veterans Administration (yearly review) has made it possible for us to determine program effectiveness, economy of operation, opportunities for improvement, and salary increases. —HELEN R. CAHILL, *senior dietetic specialist, dietetic service, Veterans Administration, Washington, D. C.*

2. Work simplification program at University Hospitals, Cleveland, whereby department heads participated in a 10-week, 20-hour course in the tools and techniques of work simplification, has resulted in better management in all departments as well as better teamwork and a better tone throughout the whole organization.—CHARLES B. WOMER, *assistant director, University Hospitals of Cleveland.*

3. Personnel policies to be effective management devices must have some basic uniformity but with broad limits with forms of control achieved through enlightened supervision. We can best improve management through working with our own people and management on the scene.—JAMES S. METCALFE, *director of public relations and advertising, Crosley Division, AVCO Manufacturing Corporation, Cincinnati, Ohio.*

4. Work measurement, the technique of reducing the break-even point, is essentially a study of work flow and methods and timing of all elements of production. It is primarily thinking in terms of the number of meals per labor hour used. — J. P. LESPERANCE, PH.D., *director, Time and Motion Study Institute, University of Miami, Coral Gables, Fla.*

5. Precosting labor is an effective management technique, for it controls the most expensive aspect of food service operation before it is used. This can be achieved by multiplying the direct labor time per meal (15 minutes) by the meal count. The work sampling method can be used too, whereby the worker is spot-checked and it is recorded whether he is or is not working. If his working time is less than 80 per cent, his job and work output are examined more closely. A third method of determining labor cost utilizes process charts and flow diagrams.—GRACE L. STUMPF, *director of dietetics, University Hospital, Ohio State University, Columbus.* ■

Salad, dessert recipes featured in menus

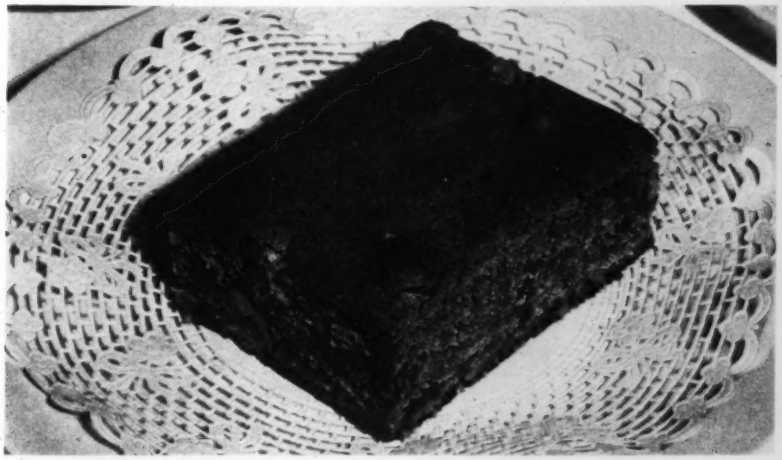
Recipes for three popular menu items at the University of Oregon Medical School Hospitals and Clinics in Portland—butterscotch chews, molded under-the-sea salad and sticky nut rolls—are presented here through the courtesy of Ruth L. Mercer, director of dietetics. Miss Mercer has included butterscotch chews as Wednesday evening's dessert on her second-week menu on page 105. Molded under-the-sea salad appears on Thursday noon's menu on page 105. Sticky nut rolls are used as Tuesday evening's dessert on the first-week menu, page 104.

The recipes are as follows:

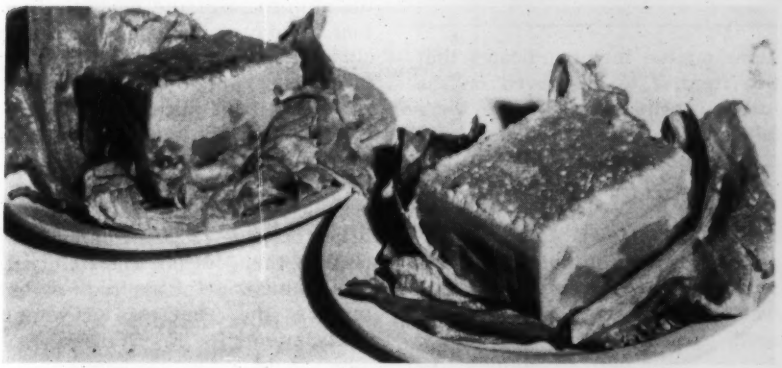
BUTTERSCOTCH CHEWS
(90 servings)

1½ lbs. shortening
5 lbs. brown sugar
12 eggs
2¼ lbs. all-purpose flour
3 tsp. salt
1½ oz. baking powder
1 lb. nuts, chopped
6 tsp. vanilla

1. Melt shortening; add brown sugar, and cook until smooth.
2. Cool mixture by placing in mixer on low speed for 15 minutes.
3. Add 6 eggs, one at a time, beating after each addition.
4. Mix and sift dry ingredients (flour, salt and baking powder).
5. Add flour alternately with the remaining 6 eggs.
6. Add vanilla.
7. Add chopped nuts to the butterscotch mixture.
8. Spread batter ½ inch thick on bottom of 18 x 26 x 2 baking sheet.
9. Sprinkle remaining nuts on top.
10. Bake in 350°F. oven approximately 20 minutes or until done.
11. Cut 60 squares per pan.
12. Serve warm or cold and serve one square per person.



BUTTERSCOTCH chews are made from a batter rich in shortening, eggs, brown sugar and nuts.



LIME flavored gelatin, cream cheese and canned pears make a colorful and nutritious salad.

MOLDED UNDER-THE-SEA SALAD
(120 servings)

4½ lbs. lime flavored gelatin
12½ qts. boiling water
4½ qts. pear juice
3 tsp. salt
12 tsp. (4 tbsp.) lemon juice
2¼ tsp. ginger
6 lbs. cream cheese
6 qts. canned pears, diced

1. Dissolve lime gelatin in boiling water. Add pear juice and cool.
2. Add salt and lemon juice to gelatin mixture and stir.
3. Pour mixture into 3 pans (18 x 12 x 2) and let stand until firm (not stiff).
4. Beat gelatin mixture in mixer (medium speed) until fluffy.
5. Add ginger to cream cheese and blend. Fold into whipped gelatin mixture.
6. Fold in diced pears.
7. Chill mixture until firm.
8. Cut 40 servings per pan.

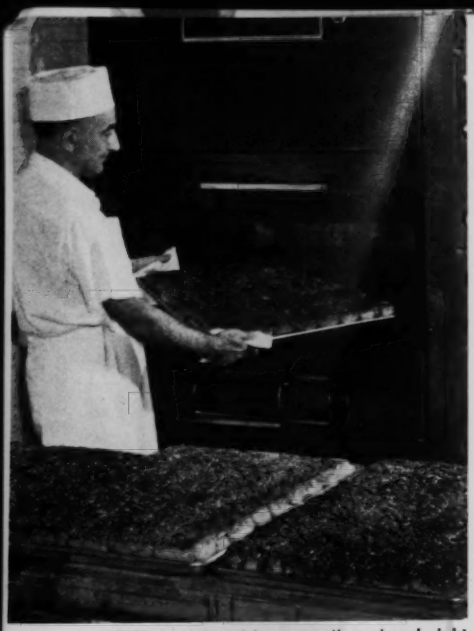
STICKY NUT ROLLS
(144-150 servings)

1½ lbs. granulated sugar
1½ lbs. shortening
12 oz. eggs
2 lbs. milk
2 lbs. water
8 lbs. all-purpose flour
4 oz. yeast

TOPPING

3 lbs. brown sugar
2 lbs. raisins (optional)
2 oz. cinnamon (optional)
2¼ lbs. margarine
1 lb. chopped walnuts

1. Prepare yeast dough. Let raise 2½ times bulk.
2. Knead dough. Let raise 1½ times bulk.
3. Roll out dough to ½ inch thickness with rolling pin.
4. Sprinkle dough with a small amount of sugar and cinnamon. Roll into one large roll.
5. Cut dough-roll into slices 1 inch thick as for cinnamon rolls.
6. Line bottom of 3 baking sheets with butter (¾ lb. per pan), brown sugar (1 lb. per pan), and chopped walnuts (5 oz. per pan).
7. Place cut rolls on top of this



AFTER baking, sticky nut rolls—placed right side up—are returned to oven for reglazing.

mixture and let the rolls raise.

8. Bake rolls in 425° F. oven for approximately 20 minutes.

9. Turn out rolls upside down, so that the nut mixture will be on top.

10. Reglaze, if necessary, by placing the baked product into the oven for a few more minutes.

NOTE: If using hard wheat flour, cut down on cake flour. ■

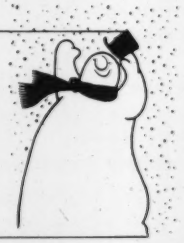
Council publishes booklet on diet and heart disease

Diet and Heart Disease, a recently published booklet of the National Dairy Council, is designed to help dietitians and other professional persons in their job of interpreting to the public the problems of diet and heart disease. Dietitians may find the booklet useful in their inpatient and outpatient nutrition education programs.

The 12-page booklet contains definitions of terms commonly used in discussing heart disease. The nature of coronary heart disease, the role of blood cholesterol and other lipids in the development of atherosclerosis, and how diet may be related to heart disease are also discussed. A list of dietary recommendations for adults in light of the present knowledge of the problem is included.

Individual copies of this booklet may be obtained free of charge by writing the National Dairy Council, 111 N. Canal St., Chicago 6, Ill. ■

Winter Cycle Menu for the North-Northwest



THE 21-DAY selective winter cycle menu and market orders for perishables are designed particularly for hospitals in the northern and northwestern sections of the United States. These menus, which may be used during December, January, and February, feature foods popular in these sections of the country.

The menus in this issue are the final set in the four-part series of winter cycle menus published in this Journal. Winter cycle menus for Midwest hospitals were included in the October 1 HOSPITALS, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION. The South-Southwest winter cycle menus were published in the October 16 issue of the Journal. The East menus were included in the November 1 issue.

In planning the menus, careful consideration has been given to keeping the menu and food production operation simple for the smaller hospital. Moreover, a moderate to low cost food budget was used.

This cycle menu features a choice of entree, vegetable, salad and dessert on the noon and night menus. Two cereals and two fruits are offered on the breakfast menu.

Since one of the choices offered is designed for use on modified diets, these menus can be used for both normal and modified diets. The letter (F) following certain items on the menu indicates that this item is to be served on the full or normal diets, while those labeled (S) are for the soft and other modified diets. Where the letters (FS) appear, the menu item can be served on both the full and soft diets.

During November hospitals may use the fall cycle menus, published in the July and August 1957 issues of this Journal. The Midwest and South-Southwest cycle menus were included in the July 1 and 16 issues, respectively. The August 1 and 16 issues featured fall menus for the East and North-Northwest, respectively.

The market order for perishables, which accompanies each week's menu, lists the meats, seafood, poultry, and fresh and frozen fruits and vegetables that a 50-bed hospital will need to produce the menu. The market order includes all portion-ready meats, oven-ready roasts, portion-ready seafood, eviscerated poultry and other pre-prepared items. The amounts are computed on the basis of serving 100 patient and personnel meals at breakfast, 125 at noon and 100 at night. By using a multiple of 50, larger hospitals can easily arrive at their market orders.

An added feature of this menu service is the standard storeroom inventory, a list of supplies that a 50-bed hospital should have in the storeroom at the beginning of each 21-day cycle. The items included are cereals and farinaceous products, canned fish, canned fruits and fruit juices, dried fruits and vegetables, jellies, cake and pudding mixes, pickles, canned soups and canned vegetables.

This list of supplies was published on page 73 of the January 1 issue of this Journal. The standard is also available upon request by writing the American Hospital Association, 18 E. Division St., Chicago 10.

FOR AMERICA'S HOSPITALS

Sexton Quality Foods

The greatest food service in America

St. John Hospital, Detroit, Michigan

Sexton sells and services directly more hospitals everywhere than any other wholesale grocer in America. First in its field, Sexton excels by providing foods famed for consistent quality and uniformity—all backed by the 74-year-old Sexton reputation. The coast-to-coast warehouses of the Sexton network always carry complete stocks of fine foods, outstanding in extent and variety—and you get fast dependable delivery through the great white fleet of Sexton trucks. Sexton service is specialized to meet institutional needs—and a trained Sexton representative will gladly assist you in ordering to fit your wants.

JOHN SEXTON & CO.
CHICAGO
LONG ISLAND CITY • SAN FRANCISCO
PHILADELPHIA • BOSTON • PITTSBURGH
DALLAS • ATLANTA
DETROIT • INDIANAPOLIS

1st WEEK NORTH-NORTHWEST SELECTIVE WINTER CYCLE MENU—prepared by Ruth L. Mercer, director of dietetics, University of Oregon Medical School Hospitals and Clinics, Portland

(Menus to be used during December, January and February)

	breakfast	noon	night
monday	Stewed Prunes **or** Blended Juice Oatmeal **or** Cornflakes Poached Egg Cinnamon Toast	Julienne Vegetable Soup Grilled Liver with Chili Sauce (F) **or** Baked Macaroni and Cheese (S) Mashed Potatoes (FS) Creamed Onions **or** Buttered Green Beans (FS) Head Lettuce—Indian Dressing **or** Pear Half with Jelly Garnish Cherry Marshmallow Ice Cream (S) **or** Grapefruit Sections	Corn Chowder Grilled Hamburgers (F) **or** Chicken Ala King on Toast (S) French Fried Potatoes Buttered Diced Beets (S) **or** Creole Lima Beans (F) Orange-Date Salad—Fruit Dressing **or** Carrot Slaw—Mayonnaise Tapioca Pudding with Peppermint Garnish (S) **or** Applesauce
tuesday	Kadota Figs **or** Orange Juice Farina **or** Bran Flakes Cereal Soft Cooked Egg Sausages	Chicken Giblet Soup Chowmein—Soy Sauce—Almonds—Chinese Noodles (F) **or** Meat Loaf—Mustard Sauce (S) Steamed Rice (FS) Five-Minute Cabbage **or** Buttered Carrots (FS) Pineapple-American Cheese Salad—Mayonnaise **or** Marinated Mixed Vegetables Strawberry Chiffon Pie **or** Sliced Peaches (S)	Cream of Mushroom Soup Roast Beef—Gravy (FS) **or** Chili Con Carne with Beans Baked Potato (FS) Spinach with Lemon **or** Baked Squash (FS) Shredded Lettuce with Roquefort Dressing **or** Apple-Grapefruit Section-Raisin Salad—Orange Dressing Sticky Nut Roll (F) **or** Vanilla Pudding with Chopped Maraschino Cherry Garnish (S)
wednesday	Sliced Banana **or** Apricot Nectar Wholewheat Cereal **or** Oats Cereal Fried Egg	Split Pea Soup Swiss Steak (F) **or** Baked Cheese Omelet—Mushroom Sauce (S) Escalloped Potatoes Stewed Tomatoes (FS) **or** Buttered Brussels Sprouts Jellied Fruit Salad—Fruit Dressing **or** Mexican Slaw—Vinegar Dressing Angel Cake with Almond Icing (FS) **or** Royal Purple Plums	Consomme Stuffed Green Pepper (F) **or** Roast Veal with Gravy (S) Oven Brown Potatoes Buttered Cauliflower (F) **or** Asparagus Tips (S) Peach Half with Cottage Cheese—Orange Dressing **or** Celery Hearts—1000 Island Dressing Brown Sugar Cookies (S) **or** Fresh Pears (F)
thursday	Pineapple Juice **or** Stewed Raisins Hominy Grits **or** Ready-to-eat Malt Flake Cereal Baked Egg with Bacon	Cream of Celery Soup Baked Chicken with Gravy—Savory Dressing (FS) **or** Italian Spaghetti—Meat Sauce Mashed Potatoes Broccoli (F) **or** Buttered Beets (S) Apple and Orange Slice Salad—Fruit Dressing **or** Pea-Cheese-Pickle Salad with Mayonnaise Pineapple Sundae (FS) **or** Fruit Cocktail	Minestrone Soup Roast Lamb—Mint Jelly (FS) **or** Fruit Salad Plate with Cottage Cheese O'Brien Potatoes Baked Squash **or** Glazed Carrots (FS) Vegetable Medley—French Dressing **or** Tossed Greens—1000 Island Dressing Caramel Custard (FS) **or** Fresh Grapes
friday	Grape Juice **or** Tangerine Wholewheat Cereal **or** Ready-to-eat Rice Cereal Scrambled Egg Sweet Rolls	Southern Bisque Crab Louis with Hard Cooked Egg—Tomato Wedge—1000 Island Dressing **or** Meat-Vegetable Pie (S) Potato Chips Buttered Peas (FS) **or** Creamed Turnips Mixed Fruit Salad—Ice Cream Dressing **or** Devilled Egg Salad with Mayonnaise Chocolate Eclairs (FS) **or** Apricots	Cream of Spinach Soup Baked Snapper—Tartar Sauce (FS) **or** Grilled Frankfurters Au Gratin Potatoes Whole Kernel Corn **or** Buttered Green Beans (FS) Apricot-Coconut Salad **or** Celery Cabbage—Russian Dressing Apple Crisp—Hard Sauce (FS) **or** Bing Cherries
saturday	Grapefruit Half **or** Orange Juice Farina **or** Ready-to-eat Wheat Flake Cereal French Toast—Syrup	Duchess Soup Broiled Lamb Steak (FS) **or** Egg Foo Yung Creamed Potatoes Grilled Egg Plant **or** Chopped Spinach with Hard Cooked Eggs (FS) Shredded Lettuce—Italian Dressing **or** Mandarian Orange Salad—Fruit Dressing Egg Nog Ice Cream (FS) **or** Dried Nectarines and Raisin Compote	Potato Chowder Baked Veal Cutlet (FS) **or** Creamed Dried Beef on Toast Buttered Diced Potatoes Buttered Asparagus (S) **or** Cauliflower Au Gratin (F) Pineapple Slice Salad—Fruit Dressing **or** Pickled Beet Salad—Vinegar Dressing Coconut Layer Cake (F) **or** Green Gage Plums (S)
sunday	Tomato Juice **or** Pear Nectar Rolled Wheat Cereal **or** Puffed Rice Cereal Poached Egg	Chicken Noodle Soup Pot Roast—Gravy (FS) **or** Veal Scallopine Mashed Potatoes Buttered Rutabagas **or** Minted Carrots (FS) Celery Hearts with Olive Garnish—Calvonnaise Dressing **or** Jellied Lime with Fruit Boysenberry Pie (F) **or** Royal Anne Cherries (S)	Canadian Cheese Soup Assorted Cold Meats (F) **or** Beef-Noodle Casserole (S) Potato Salad Buttered Peas (FS) **or** Mixed Vegetables Pickled Peach Salad—Fruit Dressing **or** Sliced Tomato—Mayonnaise Chocolate Chip Cookies (FS) **or** Whole Orange

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

1st week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Bologna	All beef	10 lbs.	
Chipped Beef, Dried	U. S. Good	2 lbs.	20
Frankfurters	All beef, 8—1 lb.	5 lbs.	20
Ground Beef	U. S. Good, 5 lb. pkg.	55 lbs.	
Liver	Steer, sliced	20 lbs.	100
Roast, Sirloin (B.R.T.)	U. S. Choice	35 lbs.	105
Round (Bottom)	U. S. Standard	30 lbs.	90
Steak, Swiss	U. S. Good, 4 oz. each	25 lbs.	100
Stew	U. S. Good	10 lbs.	40
LAMB			
Leg (B.R.T.)	U. S. Choice, yearling	30 lbs.	90
Steaks, Shoulder	U. S. Good, 5 oz. each	35 lbs.	105
PORK			
Bacon (Sliced)	24-26—1 lb.	12 lbs.	144
Ham (Pullman)	Ready-to-eat	10 lbs.	
Loin (Boneless)	Grade A, 10-12 lbs.	25 lbs.	100
Sausage, Liver		5 lbs.	
VEAL			
Chop Suey Meat	U. S. Good	20 lbs.	100
Cutlets	U. S. Good, 4 oz. each	30 lbs.	120
Shoulder (Boneless)	U. S. Good	5 lbs.	15
FISH			
Crab meat	Dungeness	20 lbs.	100
Red Snapper	Fillets	25 lbs.	100

Item, Specifications, Amounts & No. of Servings			
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	10 lbs.	
Fryers (Eviscerated)	Grade A, 2½ lb. av.	60 lbs.	100
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Bananas	Ripe	30 lbs.	
Grapefruit	Seedless, 70s	1 crate	
Grapes	Emperor	28 lbs.	
Lemons		1 doz.	
Oranges	176s	1 crate	
Pears	Box, 120s	1 box	
Tangerines	Crate, 144s	1 crate	
FRESH VEGETABLES			
Cabbage	Bag	50 lbs.	
Carrots	Topped, bag	50 lbs.	
Celery	Pascal, 30s	1 crate	
Celery Cabbage	Bunch	1 doz.	
Chicory	Bunch	3 heads	
Cucumbers		½ doz.	
Eggplant		3 only	
Lettuce	Head, 48s	2 crates	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	1 doz.	

Item, Specifications, Amounts & No. of Servings			
Parsley	Bunch	1 doz.	
Potatoes, White	Bag No. 1	300 lbs.	
Radishes	Bunch	1 doz.	
Rutabagas		5 lbs.	20
Spinach		5 lbs.	
Squash, Hubbard		40 lbs.	120
Tomatoes	Repacked (5 x 6)	30 lbs.	
Turnips, White	Topped	5 lbs.	20
FROZEN FRUITS			
Boysenberries	8 lb. can, 5-1 sugar	24 lbs.	
Orange Juice	Con., 32 oz. can	3 cans	96
FROZEN VEGETABLES			
Asparagus	Cuts, 2½ lb. pkg.	2½ lbs.	15
Asparagus	Spears, 2½ lb. pkg.	2½ lbs.	15
Beans, Green	Cuts, 2½ lb. pkg.	30 lbs.	180
Beans, Lima	Small, green, 2½ lb. pkg.	15 lbs.	90
Broccoli	Stems and buds, 2½ lb. pkg.	15 lbs.	90
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	30 lbs.	180
Peas	2½ lb. pkg.	30 lbs.	180
Spinach	Chopped, 2½ lb. pkg.	17½ lbs.	105
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

CYCLE MENU PAGES ARE PERFORATED FOR EASY REMOVAL

PLEASE CUT OUT ALONG THIS LINE

PLEASE CUT OUT ALONG THIS LINE

2nd WEEK NORTH-NORTHWEST SELECTIVE WINTER CYCLE MENU—prepared by Ruth L. Mercer, director of dietetics, University of Oregon Medical School Hospitals and Clinics, Portland

(Menus to be used during December, January and February)

	breakfast	noon	night
monday	Baked Apple **or** Orange Juice Cornmeal **or** Bran Flake Cereal Scrambled Egg	Barley Broth Mock Chicken Legs (S) **or** Beef Stew with Vegetables (F) Baked Potato Brussels Sprouts **or** Harvard Beets (FS) Spiced Apricot Salad—Ice Cream Dressing **or** Kidney Bean Salad—Vinegar Dressing Lemon Sponge (FS) **or** Pear Halves	Cream of Carrot Soup Grilled Cubed Steak (F) **or** Cheese Omelet with Parsley Sauce (S) Lyonnaise Potato Buttered Hubbard Squash (S) **or** Cream Style Corn (F) Grapefruit-Date Salad—Fruit Dressing **or** Relish Plate—Mayonnaise Orange Sherbet (FS) **or** Frozen Pineapple Tidbits
tuesday	Sliced Oranges **or** Grape Juice Farina **or** High Protein Cereal Soft Cooked Egg Sweet Rolls	Cream of Asparagus Soup Roast Turkey with Dressing (FS) **or** Spanish Rice Mashed Potatoes Green Beans (FS) **or** French Fried Eggplant Raw Cranberry Salad—Mayonnaise **or** Lettuce Hearts—1000 Island Dressing Chocolate Pudding—Fluff Topping (FS) **or** Fruit Cocktail	Corn Chowder Ham Loaf—Mushroom Sauce (F) **or** Broiled Chicken Livers (S) Baked Sweet Potato **or** Parsley Buttered Potato Buttered Peas (FS) **or** Stewed Tomatoes Molded Spice Grape Salad—Honey Cream Dressing **or** Chef's Salad—French Dressing Hot Mince Pie (F) **or** Royal Anne Cherries (S)
wednesday	Vegetable Juice **or** Blended Juice Wholewheat Cereal **or** Ready-to-eat Malt Flake Cereal Fried Egg	Chicken Giblet Soup Baked Pork Patty—Apple Ring **or** Corned Beef Hash (FS) Escalloped Potatoes Buttered Spinach (S) **or** Five Minute Cabbage (F) Jellied Vegetables—Mayonnaise **or** Grapefruit-Pimento Salad—Fruit Dressing Coconut Custard (F) **or** Royal Purple Plums (S)	Cream of Green Bean Soup Roast Beef (FS) **or** Fruit Salad Plate with Cottage Cheese and Bologna Roll Up Oven Browned Potatoes Buttered Beets (FS) **or** Buttered Broccoli Banana-Macaroon Salad **or** Raw Vegetable Salad—Vinegar Dressing Butterscotch Chews (F) **or** Sliced Peaches (S)
thursday	Tangerine **or** Orange Juice Farina **or** Puffed Rice Cereal Pancakes with Syrup	Onion Soup Grilled Salisbury Steak (F) **or** Scrambled Eggs (S) Baked Potato Julienne Green Beans (FS) **or** Buttered Mixed Vegetables Cole Slaw—Sour Cream Dressing **or** Molded Under the Sea Salad—Mayonnaise Blueberry Pie (F) **or** Grapefruit Sections (S)	Cream of Celery Soup Veal Birds—Gravy (F) **or** Welsh Rarebit on Toast (S) Hash Brown Potatoes Mashed Rutabagas **or** Buttered Peas (FS) Stuffed Fresh Date Salad **or** Relish Plate—1000 Island Dressing Jelly Roll (FS) **or** Bing Cherries
friday	Stewed Prunes **or** Tomato Juice Cracked Wheat Cereal **or** Raisin Bran Cereal Baked Eggs Sweet Roll	Oyster Stew Grilled Cheese Sandwich (FS) **or** Tamale Pie with Ripe Olives Creamed Potatoes Buttered Lima Beans (F) **or** Glazed Carrots (S) Sliced Pineapple with Royal Anne Cherry Garnish—Chantilly Dressing **or** Tomato Wedges—Italian Dressing Peach Cobbler (F) **or** Baked Apple (S)	Cream of Mushroom Soup Cod Fish Cakes **or** Grilled Loin Lamb Chop (FS) Buttered Potatoes Seasoned Wax Beans (FS) **or** Mashed Turnips Pear-Mint Salad—Fruit Dressing **or** Tossed Greens—Russian Dressing Gingerbread (FS) **or** Apricots
saturday	Sliced Banana **or** Orange Juice Oatmeal **or** Corn Flakes Scrambled Eggs	Cream of Potato Baked Ham—Mustard Sauce **or** Hungarian Goulash (FS) Steamed Potato **or** Candied Sweet Potato Buttered Asparagus (S) **or** Buttered Broccoli (F) Avocado Slices—Grapefruit Dressing **or** Pickled Beets—Vinegar Dressing Vanilla Bavarian Creme (FS) **or** Frozen Boysenberries and Cream	Julienne Vegetable Soup Roast Beef—Gravy (FS) **or** Eggs Ala Goldenrod on Toast O'Brien Potatoes Stewed Tomatoes **or** Buttered Green Beans (FS) Apricot-Raisin Salad—Mayonnaise **or** Sliced Cucumbers—Sour Cream Dressing Lady Baltimore Cake (FS) **or** Tangerines
sunday	Kadota Figs **or** Grapefruit Juice Wholewheat Cereal **or** Ready-to-eat Rice Cereal Soft Cooked Egg Sausage Patty	Turkey Rice Soup Maryland Fried Chicken (F) **or** Mushroom Omelet (S) Mashed Potatoes Mexican Corn **or** Buttered Green Beans (FS) Shredded Lettuce—Shrimp Dressing **or** Spiced Crab Apple Salad Marshmallow Sundae (FS) **or** Green Gage Plums	Hot Tomato Juice Tuna Noodle Casserole (S) **or** Grilled Spiced Ham Sandwich (F) Baked Potato Buttered Mashed Squash (S) **or** Creamed Cauliflower (F) Celery Hearts, Pickles, and Olives—Russian Dressing **or** Molded Fruit Salad—Ice Cream Dressing Grapenut Pudding (FS) **or** Applesauce

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

2nd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Ground Beef	U. S. Good, 5 lb. pkg.	30 lbs.	
Roast, Sirloin (B.R.T.)	U. S. Choice	40 lbs.	120
Round (Bottom)	U. S. Good	30 lbs.	90
Rump (Boneless)	U. S. Good	20 lbs.	100
Steaks, Cubed	U. S. Choice, 4 oz. each	25 lbs.	100
Stew	U. S. Good	40 lbs.	200
LAMB			
Chops, Loin	U. S. Choice, 6 oz. each	40 lbs.	90
PORK			
Butts, Smoked (Boneless)	Lean	20 lbs.	100
Ham (Pullman)	Ready-to-eat	10 lbs.	40
Ham, Spiced		20 lbs.	100
Shoulder (Boneless)	Grade A	5 lbs.	20
Sausage (Bulk)	Lean	25 lbs.	100
VEAL			
Cutlets	U. S. Good, 4 oz. each	25 lbs.	100
Mock Chicken Legs	U. S. Choice, 4 oz. each	5 lbs.	20
FISH			
Oysters	Select	2 qts.	

Item, Specifications, Amounts & No. of Servings			
POULTRY			
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	60 lbs.	100
Fryers (Eviscerated)	Grade A, 2½ lb. av.	60 lbs.	100
Livers, Chicken	1 lb. pkg.	3 lbs.	15
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Avocado	Ripe	6 only	
Bananas	Ripe	60 lbs.	
Cranberries	1 lb. bag	10 lbs.	
Lemons		1 doz.	
Oranges	176s	1 box	
Tangerines	Crate, 144s	1 crate	
FRESH VEGETABLES			
Cabbage	Bag	50 lbs.	
Carrots	Topped, bag	50 lbs.	
Celery	Pascal, 30s	1 crate	
Cucumbers		1 doz.	
Eggplant		6 only	
Lettuce	Head, 48s	2 crates	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	1 doz.	
Parsley	Bunch	1 doz.	
Potatoes, Sweet	Hamper	100 lbs.	
Potatoes, White	Bag No. 1	300 lbs.	

Item, Specifications, Amounts & No. of Servings			
Rutabagas		5 lbs.	20
Squash, Hubbard		5 lbs.	15
Tomatoes	Repacked (5 x 6)	30 lbs.	
Turnips, White	Topped	5 lbs.	20
FROZEN FRUITS			
Blueberries	Dry, 8 lb. can	16 lbs.	
Boysenberries	8 lb. can, 5-1 sugar	8 lbs.	
Orange Juice	Con., 32 oz. can	6 cans	184
FROZEN VEGETABLES			
Asparagus	Cuts, 2½ lb. pkg.	2½ lbs.	15
Beans, Green	Cuts, 2½ lb. pkg.	30 lbs.	180
Beans, Green	Julienne, 2½ lb. pkg.	30 lbs.	180
Beans, Lima	Small, green, 2½ lb. pkg.	15 lbs.	90
Beans, Wax	Cuts, 2½ lb. pkg.	15 lbs.	90
Broccoli	Stems and buds, 2½ lb. pkg.	17½ lbs.	105
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	15 lbs.	90
Peas	2½ lb. pkg.	30 lbs.	90
Spinach	Chopped, 2½ lb. pkg.	2½ lbs.	15
Squash, Winter	1 lb. pkg.	2 lbs.	12
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

CYCLE MENU PAGES ARE PERFORATED FOR EASY REMOVAL

3rd WEEK NORTH-NORTHWEST SELECTIVE WINTER CYCLE MENU—prepared by Ruth L. Mercer, director of dietetics, University of Oregon Medical School Hospitals and Clinics, Portland

(Menus to be used during December, January and February)

	breakfast	noon	night
monday	Grapefruit Half **or** Grape Juice Rolled Wheat Cereal **or** Bran Flake Cereal Poached Egg Sweet Roll	Mongol Soup Swedish Meat Balls (F) **or** Roast Lamb (S) Twice Baked Potatoes Creamed Onions **or** Minted Carrots (FS Carolina Salad—Sour Cream Dressing **or** Molded Double Deck Cherry Salad—Ice Cream Dressing Chocolate Cake—Seven Minute Icing (FS) **or** Grapes	Beef Barley Soup Yankee Pot Roast (FS) **or** Liver Loaf with Egg Sauce Steamed Potatoes Buttered Green Beans (S) **or** Grilled Eggplant (F) Waldorf Salad—Mayonnaise **or** Caesar Salad—French Dressing Pumpkin Pie (F) **or** Pear Halves (S)
tuesday	Tomato Juice **or** Apple Juice Farina **or** Oats Cereal Fried Egg	Pepper Pot Soup Roast Beef (FS) **or** Cheese Strata Mashed Potato Buttered Peas (FS) **or** Browned Parsnips Shredded Lettuce—Roquefort Dressing **or** Peach-Creme Cheese Balls Lemon Sherbet (FS) **or** Royal Purple Plums	Cream of Celery Sweet and Sour Spareribs (F) **or** Meat Loaf (S) Fried Rice (F) **or** Mashed Potatoes (S) Sauerkraut (F) **or** Buttered Beets (S) Orange-Spiced Grape Salad—Mayonnaise **or** Stuffed Celery and Pickle Strawberry Shortcake (F) **or** Fruit Cocktail (S)
wednesday	Orange Slices **or** Pear Nectar Wholewheat Cereal **or** Puffed Wheat Cereal French Toast—Syrup	Navy Bean Soup Stuffed Frankfurters (F) **or** Virginia Macaroni (S) Baked Potato Seasoned Green Beans (FS) **or** Stewed Tomatoes Chef's Salad—French Dressing **or** Banana Fingers in Orange Juice Apple Swirls with Cinnamon Sauce **or** Royal Anne Cherries (S)	Julienne Vegetable Soup Italian Pizza (F) **or** Steak Strips in Sour Cream (S) Buttered Potatoes Buttered Asparagus (FS) **or** Buttered Brussels Sprouts Sunset Salad—Mayonnaise **or** Tossed Greens—French Dressing Marshmallow Delight (FS) **or** Kadota Figs
thursday	Prune Juice **or** Orange Juice Hominy Grits **or** Ready-to-eat Wheat Flake Cereal Baked Egg	Mulligatawny Soup Grilled Butt Steak (F) **or** Poached Egg on Toast (S) French Fried Potatoes Creme Style Corn (F) **or** Seasoned Peas (S) Tomato Wedge—Italian Dressing **or** Stuffed Prunes and Mandarin Orange Rhubarb Torte (FS) **or** Pineapple Slices	Turkey Alphabet Soup Corned Beef—Mustard Sauce (F) **or** Broiled Hamburger (S) Parsley Potatoes Buttered Carrots (FS) **or** Sweet and Sour Red Cabbage Spiced Peach Salad **or** Molded Vegetable—Mayonnaise Apple Cobbler (F) **or** Apricots in Syrup (S)
friday	Sliced Banana **or** Blended Juice Rice Farina **or** Ready-to-eat Rice Cereal Soft Cooked Egg Sweet Roll	Clam Chowder Broiled Halibut—Tartar Sauce (FS) **or** Baked Beef Hash Au Gratin Potato Buttered Mashed Squash (FS) **or** Creole Lima Beans Spiced Crab Apples **or** Lettuce Wedge—Russian Dressing Chocolate Ice Cream (FS) **or** Green Gage Plums	Cream of Rice Soup Russian Salmon—Parsley Sauce (FS) **or** Chicken Canton Mashed Potato Buttered Broccoli **or** Seasoned Peas (FS) Frozen Fruit Salad **or** Sliced Cucumbers—Sour Cream Dressing Boston Creme Pie (FS) **or** Fresh Pears
saturday	Dried Apricot-Raisins **or** Grapefruit Juice Wholewheat Cereal **or** Bran Cereal Scrambled Egg	Consomme Beef Biscuit Roll—Mushroom Sauce (F) **or** Veal Fricassee (S) Baked Potato Mashed Rutabagas—Bacon Seasoning **or** Spinach with Lemon (FS) Grapefruit-Avocado—Calvannaise Dressing **or** Sliced Tomato—Russian Dressing Floating Island (FS) **or** Bing Cherries	Cream of Asparagus Sauerbrauten (F) **or** Scrambled Eggs (S) Duchess Potato Buttered Cauliflower (F) **or** Buttered Carrots (S) Perfection Salad—Mayonnaise **or** Apple-Date Salad—Fruit Dressing Mintwitches (F) **or** Peach Half (S)
sunday	Applesauce **or** Orange Juice Oatmeal **or** Corn Flakes Fried Egg Cinnamon Toast	Swedish Soup Roast Turkey—Dressing (FS) **or** Stew with Vegetables Mashed Potatoes Savory Green Beans (FS) **or** Seasoned Winter Squash Lettuce Wedge—Russian Dressing **or** Molded Cranberry Wedge Salad Flora Dora Pie (F) **or** Grapefruit Sections (S)	Chicken Gumbo Spanish Pork Chops (F) **or** Beef-Rice Casserole (S) Cottage Fried Potatoes Buttered Asparagus (FS) **or** Mashed Turnips Cottage Cheese with Fruit (S) **or** Relish Plate—Russian Dressing Macaroons **or** Prune Whip (FS)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

3rd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Brisket, Fresh	U. S. Good	30 lbs.	90
Frankfurters	All beef, 8—1 lb.	25 lbs.	100
Ground Beef	U. S. Good, 5 lb. pkg.	70 lbs.	
Liver	Steer, sliced	5 lbs.	20
Roast, Sirloin (B.R.T.)	U. S. Choice	35 lbs.	105
Round (Bottom)	U. S. Good	30 lbs.	90
Rump (Boneless)	U. S. Good	30 lbs.	90
Steaks, Sirloin Butt	U. S. Choice, 5 oz. each	35 lbs.	105
Stew	U. S. Good	10 lbs.	50
Tenderloin Tip	U. S. Good	25 lbs.	100
LAMB			
Leg (B.R.T.)	U. S. Choice, yearling	6 lbs.	18
PORK			
Chops, Loin	Grade A, 4 oz. each	25 lbs.	100
Sausage (Bulk)	Lean	10 lbs.	
Spareribs	Grade A, 3—1 lb.	50 lbs.	100
VEAL			
Shoulder (Boneless)	U. S. Good	10 lbs.	20
FISH			
Halibut	Steaks, 5 oz. each	30 lbs.	90
Salmon	Red, steaks, 5 oz. each	30 lbs.	90

Item, Specifications, Amounts & No. of Servings			
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	10 lbs.	
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	60 lbs.	90
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Bananas	Ripe	60 lbs.	
Cranberries	1 lb. bag	10 lbs.	
Grapefruit	Seedless, 70s	1 box	
Grapes	Emperor	28 lbs.	
Lemons		1 doz.	
Oranges	176s	1 box	
Pears	Box, 120s	1 box	
Tangerines	Crate, 144s	1 crate	
FRESH VEGETABLES			
Cabbage	Bag	50 lbs.	
Cabbage, Red		10 lbs.	
Carrots	Topped, bag	50 lbs.	
Celery	Pascal, 30s	1 crate	
Cucumbers		1 doz.	
Eggplant		8 only	
Lettuce	Head, 4Bs	2 crates	
Onions, Dry	Yellow, bag	30 lbs.	
Onions, Green	Bunch	1 doz.	
Parsley	Bunch	1 doz.	

Item, Specifications, Amounts & No. of Servings			
Parsnips		5 lbs.	20
Potatoes, White	Bag No. 1	300 lbs.	
Squash, Hubbard		5 lbs.	20
Tomatoes	Repacked (5 x 6)	30 lbs. (1 lug)	
Turnips, White	Topped	5 lbs.	20
FROZEN FRUITS			
Orange Juice	Con., 32 oz. can	3 cans	96
Rhubarb	8 lb. can, 5-1 sugar	8 lbs.	
Strawberries	Sliced, 8 lb. can, 5-1 sugar	24 lbs.	
FROZEN VEGETABLES			
Asparagus	Cuts, 2½ lb. pkg.	30 lbs.	180
Beans, Green	Cuts, 2½ lb. pkg.	17½ lbs.	105
Beans, Green	Julienne, 2½ lb. pkg.	15 lbs.	90
Beans, Lima	Small, green, 2½ lb. pkg.	2½ lbs.	15
Broccoli	Stems and buds, 2½ lb. pkg.	2½ lbs.	15
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	15 lbs.	90
Peas	2½ lb. pkg.	32½ lbs.	195
Spinach	Whole leaf, 2½ lb. pkg.	15 lbs.	90
Squash, Winter	3 lb. pkg.	15 lbs.	90

PLEASE CUT OUT ALONG THIS LINE

CYCLE MENU PAGES ARE PERFORATED FOR EASY REMOVAL

Have you tried these shortcuts to popular low-cost meals?

Save money! No costly ingredients to prepare . . . no waste . . . no guesswork! Each Chef product is a complete formula, prepared *by chefs for chefs* in the institution, hotel and restaurant fields. All designed for convenient, economical mass feeding. **Save time!** Ravioli, Sauces, *all* fine Chef products come *ready to serve*—make appealing meals in minutes. *Always popular* . . . so serve them regularly!

Yield per #10 can: 14 servings
Cost per serving: 10¢ to 11¢

Chef Ravioli is a complete main dish: tender macaroni pies filled with pure beef, cooked in a rich Italian-style meat-tomato sauce.

Yield per #10 can: 21 servings. Cost per serving: 6¢

Chef Sauce is a brown sauce base with tomato, beef (*or mushrooms*), and special Italian seasonings . . . has the desired clinging quality found only in the better sauces. Perfect on spaghetti, rice, meats, vegetables—or as the base for chefs' own formulas.

Serve Chef for menu variety

Available from your institution wholesale distributors.

Write today for product folder, cost portion chart which gives yield per can and cost per serving. Free samples available, too. Please specify product.

- Ravioli
- Spaghetti and Meat Balls
- Spaghetti Sauce with Meat or Mushrooms
- Spaghetti with Tomato Sauce and Cheese
- Sauce with Meat Balls
- Chili Con Carne with Beans
- Meat Balls with Gravy

Institution Products

***Made in the Chef Boy-Ar-Dee® kitchens of**

AMERICAN HOME FOODS

Division of American Home Products Corporation, 22 East 40th Street, New York City

book reviews

chronic disease problems

also:
hospitals and alcoholism
supervisory training

CHRONIC ILLNESS IN THE UNITED STATES; VOL. I: PREVENTION OF CHRONIC ILLNESS. Commission on Chronic Illness. Cambridge, Published for the Commonwealth Fund by Harvard University Press, 1957. 338 pp. $8.50.

This is one of a set of four volumes on chronic illness based on the work of the Commission on Chronic Illness, a national voluntary group which, from 1949 to 1956, studied the chronic illness problems in the United States. (A review of Volume 2; *Care of the Long-Term Patient* appeared in the May 1, 1957, issue of **HOSPITALS**, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION.)

The volume on prevention of chronic illness is broad in scope and, with reference to the first 107 pages constituting Part I, is especially useful to a wide range of disciplines in the health field, to civic organizations, educators and legislative bodies. Part II presents summaries of information on prevention of selected chronic diseases and contributory factors. Both parts of this work are valuable reading for hospital administrative personnel.

The problem of chronic disease is growing steadily as a result of the increasing life span of an increasing population. This does not mean that the problem is one of merely caring for an increasing number of aged, inasmuch as more than two-thirds of the chronically ill are under the age of 65. Hospital administrators, alert to the potential need of an increasing population group with high hospital utilization rates, will quickly recognize the value and necessity of preventive measures. This book identifies and explains such measures in logical fashion, carefully analyzing difficulties as well as setting forth methodology.

Hospital board members and administrators will find in this volume the information and the incentive to cooperate with other community agencies in formulating and executing a program of prevention of chronic illness—one of the most pressing problems today.—CARL K. SCHMIDT JR., *superintendent, Oak Forest Institutions, Oak Forest, Ill.*

Hospitals and alcoholism

HOSPITAL TREATMENT OF ALCOHOLISM. Robert S. Wallerstein. New York, Basic Books, Inc., 1957. 212 pp. $5.

This very interesting and detailed treatise is a report of four modalities for treating alcoholics in a special hospital setting over a stay of 60 to 90 days for each patient. It represents the results of an extensive research project at the Winter Veterans Administration Hospital, Topeka, Kan. Contrary to what might be inferred from the title, it is not a description of treatment for the average alcoholic patient in a general hospital setting.

Four types of therapy are described: antabuse, conditioned reflex, hypnotherapy and closed ward milieu. A two-year follow-up on the patients is included in the report. The methods and details of each therapy, the classifications of the different types of patients involved, the results achieved, and the problems of each method are described and tabulated. The immense value of this work can best be appreciated by those particularly interested in the special therapies of alcoholism carried out in special hospital settings where long-term treatment and observation is possible.

With the group undergoing milieu therapy as the control, the other techniques were compared for effectiveness. Criteria for improvement are listed and described. The authors at the outset state their belief that primary alcoholism does not exist but that it is symptomatic of an underlying psychiatric condition. The criteria for improvement, therefore, would not be acceptable to those who believe that total abstinence is the only measure of success in therapy. For the techniques described and the long-term therapy involved, the results of the special techniques could hardly be called encouraging. Of them all, the antabuse therapy seemed most effective in maintaining abstinence.

From the viewpoint of the psychiatrist, the research investigator, and those especially interested in the dynamics and therapy of alcoholism, this represents a valuable study. The references, indices, tables, and charts are unusually clear and complete. They offer exceptional opportunities for evaluation of patient category and comparative effects of the therapies.

Dr. Karl Menninger's introduction is a pointed if not optimistic prelude.—MARVIN A. BLOCK, M.D., *chairman, American Medical Association Committee on Alcoholism, Council on Mental Health.*

Supervisory training

SUPERVISORY DEVELOPMENT FOR HOSPITALS; A SELECTED ANNOTATED BIBLIOGRAPHY. Beverly F. Dordick. St. Louis, Catholic Hospital Association, 1957. 88 pp. $2.

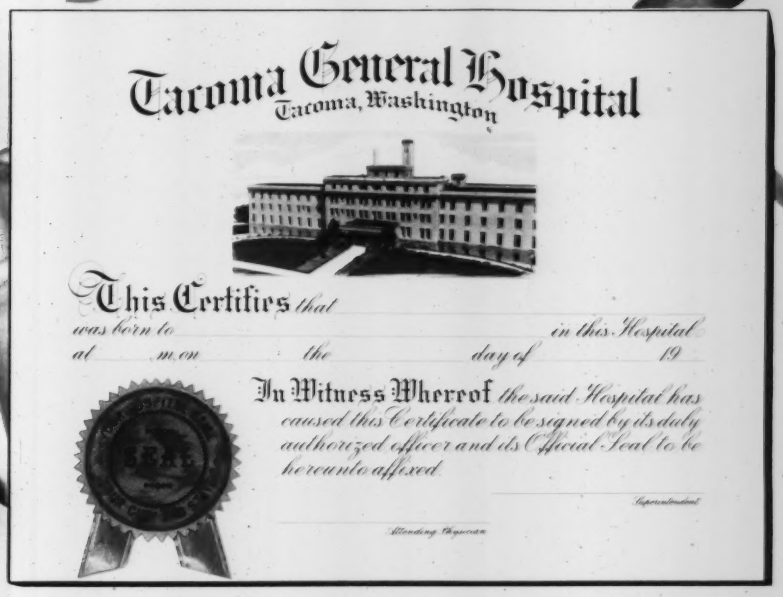
This bibliography is the first of its kind directed specifically at hospitals. Although most of the selections are written for industrial purposes, administrators as well as supervisors will find it a valuable reference book. Much of the information found in the listed documents can be readily adapted to the hospital situation.

The materials are compiled under headings which outline the major functions of a supervisor. This enables the reader to find references easily and quickly. The last chapter is devoted to a listing of the various programs of supervisory training that are being conducted successfully by industry and the federal services.

Of particular value are the annotations which describe briefly the contents of the documents, and the appendices listing periodicals of interest to the supervisor and sources of information on training films.—CATHARINE H. LOUCKS

Free! Deluxe New '57 Portfolio brings you actual samples, and a

New Idea for Spreading Goodwill in your community


Tacoma General Hospital
Tacoma, Washington
This Certifies that
was born to
in this Hospital
at m. on the day of 19
In Witness Whereof the said Hospital has caused this Certificate to be signed by its duly authorized officer and its Official Seal to be hereunto affixed.
Superintendent
Attending Physician

New Style FX *Ribboned* Certificate complete with ribbon under seal ready for embossing. Less than 20¢ each in 1000 lots — only $79 for 250.

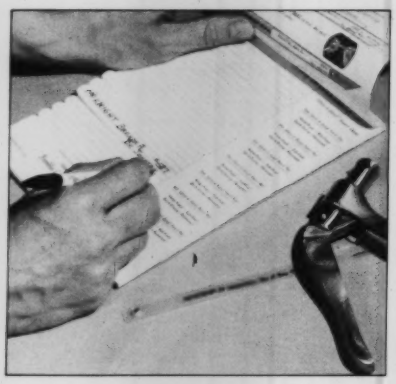
SATIN RIBBONED Birth Certificates

Want to see something beautiful — something entirely new for building goodwill among new parents, their relatives and friends? Then write for the exciting new '57 Portfolio of Hollister *Inscribed* Birth Certificates. Sixteen pages of information, pictures, prices. Contains actual samples of the new *ribboned* Certificates and a generous variety of sample Certificates with standard seals. When you receive your portfolio, notice the effectiveness of the additional note of color in the ribboned Certificates. Consider what a thrill you'll give the new parents when you present this heirloom quality token of your interest and goodwill. And remember . . . your gift of any Hollister Certificate makes a big impression and a lasting one for very little money. A letter or postcard will bring this Deluxe '57 Portfolio promptly. Write for it.

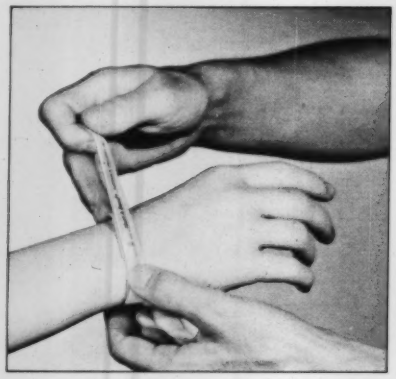
Franklin C. Hollister Company + 833 North Orleans Street, Chicago 10, Illinois

Hollister® Inscribed® Birth Certificates

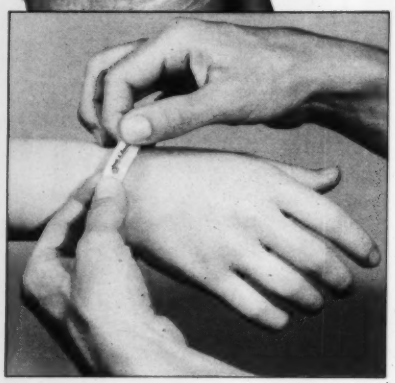
Demonstration shows how you can avoid identification worry



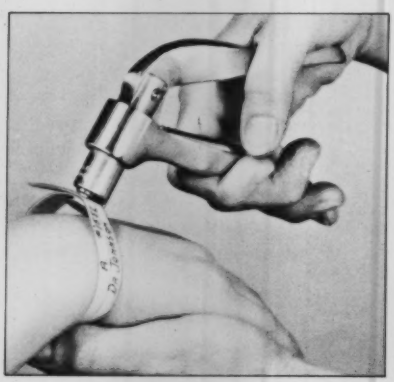
1 **YOU WON'T WORRY,** once you provide Ident-A-Band on-the-wrist protection for your patients. And when you see how everything in the system is planned to make it easy, you'll really rejoice. Ident-A-Band insert cards, for example, provide generous room for all data.



2 **WITH IDENT-A-BAND** there's no need to apply a band that's just a little too tight for comfort or a little too loose for security. The wrist is measured with the band itself (see above). Then punch hole, clip off surplus band, insert card and band's ready for fastening. All in seconds!



3 **EASY FASTENING!** The metal seal is made up with the band in manufacture so that it's already in place – ready to go through the hole you punched. Very slight finger pressure does it. That's all there is to it. And the band is in place ready for sealing—all data inside the band.



4 **SEALING INSTRUMENT** makes "custom fitting" quick and easy. A gentle squeeze and the seal is locked permanently. Easy as using a hemostat! Smooth metal seal is rivet strong. Ident-A-Band is the *one* system that provides positively *sealed-on* protection.

5 **A QUICK TRIM** and Ident-A-Band is ready to protect against misidentification for days, weeks, even months. Light weight. Comfortable. (The skin-soft Vinylite band is Mylar-reinforced for strength.) Even the chubby newborn wrist, which requires a snug fit, is no problem.

6 **BE SURE** that your system of patient identification gives the positive *permanently sealed-in* protection that really FREES you from worry about possible mixups. Send a postcard or letter now for samples of Ident-A-Band—the system that *rivet-seals* all identifying data inside.

Ident-A-Band® prevents mixups

HOLLISTER® FRANKLIN C. HOLLISTER CO., 833 N. Orleans St., Chicago 10, Ill.

personnel changes

● **William A. Clermont** has been appointed administrator of Alice Hyde Memorial Hospital, Malone, N. Y. He was formerly administrative assistant at Waterbury (Conn.) Hospital. Mr. Clermont is a graduate of the Yale University program in hospital administration.

MR. CLERMONT

● **Walter V. Coburn** has been appointed administrator of Bethany Hospital, Kansas City, Kans., succeeding the late **Bruce W. Dickson** (HOSPITALS, J.A.H.A., Sept. 1). Mr. Coburn was formerly administrator of Ransom Memorial Hospital, Ottawa, Kans. He is a graduate of the University of Minnesota program in hospital administration.

● **Robert Cole** has been appointed administrator of Bradford (Pa.) Hospital succeeding **Fred W. Schmid** who recently resigned.

● **Frank J. Dunning** has been appointed administrator of the Camelback Sanatorium and Hospital, Phoenix, Ariz. He was formerly administrator of St. Joseph's Hospital, Phoenix.

● **Clifford L. Gardner** has been appointed administrator of Williamson County Hospital, Franklin, Tenn., which is to be in operation on approximately Jan. 1, 1958. He was formerly assistant administrator of Maury County Hospital, Columbia, Tenn.

MR. GARDNER

MISS IANNELLO

● **Marian R. Iannello, R.N.,** has been appointed administrator of Ransomville (N. Y.) General Hospital. She was formerly area supervisor of welfare institutions for the New York State Department of Social Welfare.

● **Albert W. Jones** has been appointed administrator of Bethesda Hospital, Zanesville, Ohio. He was formerly assistant administrator of Ball Memorial Hospital, Muncie, Ind. Mr. Jones succeeds **George A. Judy** who recently retired.

● **Hal V. King** has been appointed assistant administrator of Salem (Ore.) Memorial Hospital. He was formerly administrative resident at Swedish Hospital, Seattle, Wash. Mr. King is a graduate of the Northwestern University program in hospital administration.

● **Edward H. Knight** has been appointed administrative assistant at Vancouver (British Columbia) General Hospital. He was formerly administrator of Prince Rupert (British Columbia) General Hospital.

● **John E. Paplow** has been appointed executive director of Lima (Ohio) Memorial Hospital. He was formerly administrator of Santa Barbara (Calif.) Cottage Hospital. Mr. Paplow is a graduate of the Northwestern University program in hospital administration.

● **Garnett L. Radin, R.N.,** has been appointed assistant director of Shriners Hospital for Crippled Children, Lexington, Ky. She was formerly an administrative resident at Jackson Memorial Hospital, Miami, Fla. Mrs. Radin is a graduate of the Northwestern University program in hospital administration.

● **Paul M. Schmoll** has been appointed manager of the Veterans Administration Center, Whipple, Ariz. He was formerly assistant manager of the VA Center in Fargo, N. Dak. Mr. Schmoll succeeds **Thomas O. Lake, M.D.,** who has retired.

● **David V. Shaw** has been appointed administrator of Dukes Memorial Hospital, Peru, Ind., succeeding **Robert Moss** who has been appointed administrator of Doctor's Hospital, Cleveland.

● **Sister Catherine Dominic, O.P.,** has been appointed administrator of Rogers (Ark.) Memorial Hospital. She was formerly the hospital's anesthetist.

● **Sister Daniel Marie** has been appointed assistant administrator of St. Francis Hospital, Hartford, Conn. She was formerly a resident at St. Vincent's Hospital, New York City, and is a graduate of the St. Louis University program in hospital administration.

● **Sister M. De Paul** has been appointed administrator of Ponca City (Okla.) Hospital. She is a graduate of the St. Louis University program in hospital administration.

● **Sister Maureen, R.S.M.,** has been appointed administrator of Mercy Hospital, Bay City, Mich., succeeding **Sister Mary Maurita, R.S.M.** who has been appointed administrator of St. Mary's Hospital, Grand Rapids, Mich.

Sister Maureen was formerly administrator of Mercy Hospital, Cadillac, Mich., and was succeeded by **Sister Mary Grace, R.S.M.** (see above).

Sister Mary Maurita is a graduate of the St. Louis University program in hospital administration.

● **Sister Mary Grace, R.S.M.,** has been appointed administrator of Mercy Hospital, Cadillac, Mich. She was formerly administrator of Mercy Community Hospital, Manistee, Mich.

● **Sister Mary Ida, R.S.M.,** has been appointed administrator of Mercy Hospital, Manistee, Mich., having formerly served as business office manager at Mercy Hospital, Muskegon, Mich.

Deaths

● **Reginald M. Atwater, M.D.,** died Oct. 18 in Bronxville, N. Y. He was 65. He was executive secretary of the American Public Health Association from 1935 until his death.

● **William C. Gronert,** superintendent of Walther Memorial Hospital, Chicago, died Oct. 30 following an automobile collision near his home in Arlington Heights, Ill. Mr. Gronert, 56, was an outside auditor for the Federal Reserve Bank of Chicago for many years and served for 26 years on the board of Walther Hospital before being named superintendent of the institution.

THE LAW IN BRIEF

Legal matters of interest to the hospital field prepared by the law department of the American Hospital Association

Authority for Autopsy

Who may authorize an autopsy? Generally this matter is covered by statute. When the statute is not clear it is for the courts to ascertain the rights of relatives. A recent case in the Oklahoma courts illustrates this point.

In re Autopsy *of J. Roy Kyle,* 309 P. 2d 1070 (Okla., 1957), pointed up an ambiguity in the state autopsy statute. There was provision for authorization of an autopsy by the surviving husband or next of kin. The statute made no mention of the rights of the widow. In this case the next of kin, under the usual definition of that term referring to blood relatives, were three sisters of the deceased who had authorized the autopsy. The widow had refused such authorization, however.

The court decided that next of kin in this instance would include the widow; the widow has a natural and moral right to provide for burial and the statute should not be read to ignore this right in favor of absurd consequences; and, the purpose of the act was to make someone responsible for burial and not to circumvent the natural right of the widow in ascertaining the method of disposal of the remains.

Loyalty Statements

Some states have required their employees to take a loyalty oath as a condition of further employment. These oaths have also been required of certain persons who are not employed by the state. For example, the Pennsylvania Loyalty Act of 1951 necessitates the filing of annual loyalty statements by those hospitals with schools of nursing.

California has a statute which requires a claimant for tax exempt status to file a loyalty statement with its tax return. This law was tested and upheld by the California Supreme Court in *First Unitarian Church of Los Angeles v. County of Los Angeles,* 311 P. 2d 508 (Cal., 1957).

The court considered and rejected the argument that the loyalty statement was an imposition on the freedom of speech and religion guaranteed to the church

On our floor
THIS "28" IS REALLY A FUNCTIONAL BOTTLE. WITH THESE THUMB AND FINGER GROOVES, IT'S ALMOST IMPOSSIBLE TO DROP IT!
JUST RIGHT FOR MY SMALL HANDS. EVEN WHEN THEY'RE WET, I FEEL SAFE WITH THIS BOTTLE.
A FUNCTIONAL LABEL, TOO... GRADUATIONS ON BOTH LABEL AND BOTTLE MAKE IT EASY TO CHECK FLUID LEVELS FROM ALMOST ANY ANGLE. AND THE PEDIATRIC SIZES HAVE 10cc. GRADUATIONS.
BAXTER LABORATORIES, INC.
Morton Grove, Illinois

under the federal constitution. Pointing out that freedom of speech and religion are not absolute, the opinion contends that the primary purpose of the statute is to protect the revenue of the state from those who would seek to destroy it by unlawful means. It is not freedom of belief which is affected by the loyalty statute but freedom to act; the court considered advocacy of subversive doctrines to be action rather than mere belief.

Thus, over the dissent of three of the seven justices, the California Supreme Court has approved the statute requiring tax exempt institutions to submit a loyalty declaration to the local tax assessor under penalty of losing their real estate tax exemption. The United States Supreme Court has agreed to review this case.

Doctors as Hospital Employees

Another recent case decided by a federal court involving Pennsylvania law portends further hospital liability for acts of the medical staff. In *Brown vs. Moore*, the U. S. Court of Appeals for the Third Circuit held, on June 27, 1957, that a private proprietary sanitarium is responsible for the malpractice of its salaried physician. The doctor was not an independent contractor in this instance since he held the title of medical director and was employed to run a sanitarium maintained for private profit.

In Pennsylvania charitable hospitals are immune from suit arising out of the negligence of their employees. In proprietary hospitals it has been assumed, and in this case determined, that there is no hospital immunity from suit for employees' negligence. Staff physicians, however, usually have been held responsible for their own malpractice regardless of the hospital's immunity position.

This case is especially interesting because of the language of the court regarding the status of a private physician practicing at a proprietary hospital and the possible legal responsibility of the hospital for the doctor's malpractice even though the doctor is not an employee of the hospital. Assuming that the doctor was an independent contractor, the court was of the opinion "that where there has been a holding out, a representation to a patient or to his family as members of the public, that medical treatment is to be administered in a private hospital or sanitarium by a doctor employed therein, the courts of the Commonwealth of Pennsylvania would apply the doctrine of *respondeat superior* and hold the owners or operators of the sanitarium liable for the malpractice of the doctor."

The doctor's dual legal status was explained in this fashion. He "could be regarded as having the status of an independent contractor in his relation to the partners of the sanitarium but in his relation to [the patient] would be deemed to be an employee of the sanitarium."

We have seen this "holding out" theory applied in recent cases in other states with the result that hospitals were charged with the negligence of staff physicians who were admittedly in private practice but who were considered to be "held out" to the public by hospitals acting as providers of medical treatment.

THE NEW POUR BOTTLES HAVE THE SAME FINGER GROOVES . . . THEY'RE REALLY EASY TO HANDLE!
YES, INDEED . . . AND HAVE YOU NOTICED HOW MANY OTHER WAYS THEY CAN BE USED ALL OVER THE HOSPITAL.

ploneering parenterals for a quarter century

Solutions emerge glistening clear and sterile from Castle Nickel-Clad Steel sterilizer.

"Build in a sterilizing set-up that's easy-to-use, easy-to-maintain,"

...said the building committee for the new, 800-bed Montreal General Hospital

Castle's planning service came up with the answer . . . based on Nickel-Clad Steel and Monel* nickel-copper alloy sterilizing equipment.

Easy-to-use. Well-planned layout of sterilizing facilities and automatic control features in the Castle units save time...effort. Make it easier to achieve more uniform sterile technique, too.

And how easy to clean the units. Just wipe with damp cloth. Dried deposits come right off with scouring powder.

Commercial cleansers won't hurt a Monel surface. In fact, *hardly anything* harms Monel nickel-copper alloy. Surfaces stay smooth . . . seldom scratch or dent. True of Nickel, too.

Easy-to-maintain. Monel-walled sterilizers resist corrosion. Monel alloy often serves twenty to thirty years with very little care.

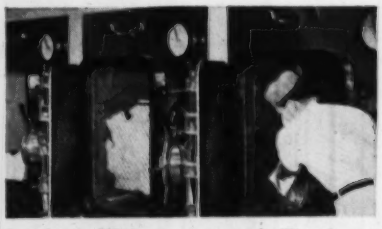
Castle puts Monel alloy in both walls of their cylindrical units, and in the end rings. All welded into one. No rivets to work loose causing leakage.

You should hear the nice things nurses at Montreal General say about the auxiliary equipment made with Monel nickel-copper alloy . . . racks, trays, operating-room equipment.

Are you building a new hospital . . . or renovating? Write Wilmot Castle Co., Rochester 2, New York. Or call their local office. Their planning service will be glad to help you, too.

*Monel is a registered trademark of the International Nickel Company, Inc. applied to nickel-copper alloys produced and marketed by it.

The International Nickel Company, Inc.
67 Wall Street New York 5, N. Y.



Lasting efficiency assured. Thanks to Monel nickel-copper alloy and Lukens Nickel-Clad Steel, personnel at Montreal General should have an easier time of it for years. In Central Sterile Supply, sterilizer cleaning is no big chore. Packs are less apt to be stained. Equipment shines. "Engineering" benefits, too, when so little need be done to maintain the equipment.

INCO TRADE MARK **Nickel Alloys**

Nickel-Clad and Monel sterilizers... *easy to care for*

WASHINGTON REPORT

Get Aid at Local Level: Eisenhower

October was "medical education month" in Washington. President Eisenhower, his secretary for health, education, and welfare, and two top-level HEW officials spoke on separate occasions about the need for promoting medical education in the United States.

The President, in a major address on Oct. 22 before a meeting of the National Fund for Medical Education, sounded a national call for increased private financing of U.S. medical schools and de-emphasis on requests for federal assistance in such programs.

He said the problem of medical school education must be met "through the leadership of citizens who are aroused to a crucial need and who will arouse others."

There are ways in which local, state, and federal governments may properly contribute to medical education, the President said, but essentially "medical education is a mission demanding broad private effort. For government to take over all responsibility in this critical field would signal the onset of a grave infection of our nation's spirit . . .

"The necessary and constructive use of government . . . must not lead to a doctrinaire and expedient reliance upon government . . . With . . . our belief in freedom we have become more critically insistent not only that the necessity and value of governmental activities be clearly demonstrated, but that these activities be conducted at a level as close as possible to the people . . .

"Let a way be found," the President said, "to transfer federal activities to the state—with appropriate tax resources — in fields where federal intervention has already served its original purpose of enlisting state or local effort, where the desirability of federal intervention has never been convincingly established."

In praising "the wise philosophy of corporate support for higher education . . ." the President pointed out that corporation contributions to education in 1948 were $25 million and that in 1956 they exceeded $100 million.

He said, however, that America's 83 approved medical schools require $10 million more a year to balance their fiscal budgets "and many more dollars to meet their existing academic deficits"; there is, he continued, a "rapid accumulation of new medical knowledge flooding in like a tide . . ." so that in the space of "a few decades" the cost of producing a qualified doctor has quadrupled.

"Accordingly," President Eisenhower stated, "there is—today—a great gap to close; the gap between the ceiling of medical school receipts from all sources and the racing increase in costs of teaching, research and medical care. But the gap which the United States will face tomorrow will be still wider and deeper.

"These schools," he said in making his plea for greater nonfederal contributions to medical education, "are turning out scarcely enough physicians to care for America's present population of 172 million" and with an expected population increase of 56 million by 1975 "many new schools of medicine must soon be put into operation."

Secretary Folsom, speaking 24 hours in advance of the President told the Association of American Medical Colleges in Atlantic City, N.J., that medical school needs must increasingly be met through organized medicine itself as well as corporate giving by American business and the general community.

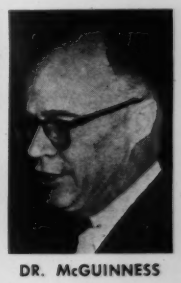
PRES. EISENHOWER

SEC. FOLSOM

Neither the President nor Secretary Folsom made mention of last year's administration request for the $225 million five-year program of matching funds to aid medical schools in meeting their current and projected needs.

HEW undersecretary John A. Perkins, speaking in Washington on the needs for higher education said, "we must tax ourselves and make benefactions to finance the breakthrough in education to a higher level of quality and quantity. It is up to each of us to support both public and private education if the democratic way is to meet the test."

MR. PERKINS



DR. McGUINNESS

HEW special health assistant Dr. Aims C. McGuinness, a few days later called for increased public attention to the needs of the nation's medical schools which he said were facing serious financial problems. Dr. McGuinness claimed that the need for trained scientific personnel covers the entire range of health professions. He said, "the well spring of the scientific personnel need in this great effort is the modern medical school."

MILITARY SURGEONS MEET

"Disaster medicine" was the subject of an entire day's discussion at the Association of Military Surgeons of the United States 64th annual convention, held in Washington, D.C., Oct. 28-30.

Featured in the program were panels and discussions on proposed plans for community mutual assistance in the event of mass casualties.

The military plan for handling a large number of casualties, developed by the Air Force surgeon general for carrying out its wartime mission, was presented as being readily adaptable to civilian community medical planning.

Some 1500 delegates from all

over the world attended the meeting.

COMMITTEE ON AGED

Government assistance in training personnel for nursing and domiciliary homes has been recommended by the National Advisory Committee on Chronic Illness and Health of the Aged. The recommendation was made at the newly formed committee's first meeting last month.

TUBERCULOSIS INCIDENCE

Despite a 30 per cent decline in active tuberculosis cases since 1952, there are still approximately 250,000 victims today, some 40 per cent of whom are unknown to medical and public health authorities.

This is among the information found by the Public Health Service and the National Tuberculosis Association based on their first jointly conducted survey of tuberculosis in this country since 1952.

Approximately 2 million Americans are ill, or have been ill, with tuberculosis. Of this total, 1.2 million are former patients, 550,000 have inactive tuberculosis requiring continuous supervision, and the remaining 250,000 are active cases, the survey report stated.

RESEARCH GRANTS

During the first third of the government's current fiscal year, research grants totaling $46,031,816 were awarded by the National Institutes of Health. Medical schools, hospitals and various research centers shared in 3325 grants.

Projects in 478 institutions, scattered over all 48 states and territories and 18 foreign countries, received support. Slightly under one-third of the awards, $15,631,011, were for new projects and the remainder were continuation or supplemental grants.

By component institutes, the distribution was as follows:

	No. Grants	Total
National Cancer Institute	384	$ 5,998,111
National Heart Institute	642	9,601,557
National Institute of Allergy and Infectious Diseases	620	7,666,510
National Institute of Arthritis and Metabolic Diseases	579	7,137,003
National Inst. Dental Research	105	968,892
Natl. Inst. Mental Health	189	3,938,065
Natl. Inst. of Neurological Diseases and Blindness	357	4,740,663
General (Div. Research Grants)	449	5.981,015
	3325	$46,031,816

MEDICAL FACILITIES LOANS

The Public Health Service is soon expected to announce approval of applications for matching funds to help finance construction of medical research facilities. Late last month the National Advisory Health Research Facilities Council held a three-day meeting to pass on applications.

The council's recommendations were predicated on congressional approval of another $30 million appropriation in 1958. To date $60 million has been granted for the program, of which $56.5 million has been committed. The program will end in June 1959, unless it is continued by Congress.

ADVISORY COUNCIL

Twelve members have been appointed to the Advisory Council on Social Security Financing, HEW Secretary Folsom has announced. Duties of the new council include a complete review of the Old-Age and Survivors Insurance Trust Fund and the Disability Insurance Trust Fund. Authority for the council, which is to make its report by the end of 1958, was provided by the last Congress.

INSURANCE ADS BEFORE COURT

The 1957-58 term of the U. S. Supreme Court will be asked to rule on federal jurisdiction over advertising claims for hospitaliza-

State Association Presidents

CALIFORNIA

DR. W. W. STADEL
Director
Department of Medical Institutions
San Diego County

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE

DR. RUSSELL A. NELSON
Director
Johns Hopkins Hospital
Baltimore
(997 beds)

OKLAHOMA

JACK W. SHRODE
Administrator
Wesley Hospital
Oklahoma City
(200 beds)

UTAH

KENNETH E. KNAPP
Administrator
Thomas D. Dee Memorial Hospital
Ogden
(226 beds)

VIRGINIA

RAYMOND E. HOGAN
Administrator
Giles Memorial Hospital
Pearisburg
(64 beds)

WEST VIRGINIA

A. C. WEAVER
Administrator
Charleston General Hospital
Charleston
(240 beds)

tion and medical care insurance.

Petitions for certiorari, or review, of appellate court decisions have been filed by the Department of Justice. The Fifth and Sixth Circuit Courts of Appeal recently overturned cease and desist orders entered by the Federal Trade Commission against the American Hospital and Life Insurance Co. and the National Casualty Co.

SHIFTING GOVERNMENT FUNCTIONS

The Joint Federal-State Action Committee, or so-called "Governors Committee", investigating the feasibility of shifting some government functions and tax sources from the federal to the state and local level, has agreed to promote only a "limited demonstration" of such a trend.

John H. Stambaugh, special assistant to the President and executive director of the action committee, said that only seven government functions had been identified and none of these touch significantly on the health or hospital fields.

Among the "emergency problems" which the joint committee expects to at least review this fall are the aging and the aged, mental health, and education beyond the high school. The latter investigation may touch on medical schools and nurse training.

Mr. Stambaugh said that the action committee set a Dec. 1 deadline in the hope that the President would incorporate some or all of the committee's proposals in his State-of-the Union and budget messages to Congress after the first of the year. The proposals will also be presented to the executive committee of the governor's conference meeting Dec. 5 at Hot Springs, Ark.

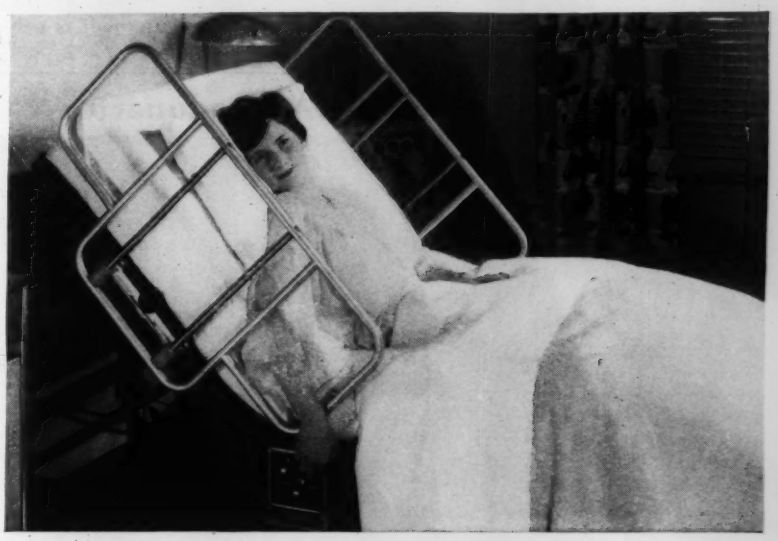
By agreeing to a "limited demonstration," the committee hoped to avoid arousing such powerful opposition that might be expected to destroy its attempt to establish at least a beginning of a trend towards turning federal responsibilities back to the states and local communities, according to Mr. Stambaugh.

New York Hospital Post Filled

Dr. Henry I. Fineberg, medical superintendent of the Queens Hospital Center, Jamaica, N. Y., has been appointed deputy commissioner of hospitals of New York City. Dr. Fineberg was recently sworn into the $17,500-a-year job by Mayor Robert Wagner.

any height . . . any spring position at the touch of a button . . .

by either patient or nurse



with the all-electric "PUSH-BUTTON" Hilow Bed

by Hill-Rom

● This new Hill-Rom Hilow Bed is designed so that operation of the hilow feature and adjustment of the backrest and knee rest may be handled by either patient or nurse. Push button controls for patient use are located on the patient's right—in the seat section of the spring. For the patient who must remain in a certain prescribed position, the bed may be placed in that position and the patient control switches then rendered inoperative. All switches are mechanically interlocked—no two push buttons can be operated at the same time.

Maximum convenience for the nurse, maximum comfort and safety for the patient

This modern, safe and efficient hilow bed can be maintained at the "low" position at all times to insure maximum safety. Much time will be saved the nurse by elimination of unnecessary trips to the patient room or unit. The patient has access to head and knee rest and does not need the nurse for routine adjustment of the spring.

Head end and foot end panels, designed by Raymond Loewy, add to the appearance and function of the bed. For complete information on this or any of the three other Hill-Rom Hilow Beds, write for Procedure Manual No. 3.

HILL-ROM COMPANY, INC. • Batesville, Indiana

Now ready . . . **Procedure Manual No. 3—"Hilow Beds"** by Alice L. Price, R.N., M.A., Nurse Consultant for Hill-Rom, and author of three leading textbooks on nursing, also P.M. No. 1, "Safety Sides—A New Safety Measure" and P.M. No. 2, "The Recovery Bed, Labor Bed, Special Therapy Bed." Copies of any of these manuals for student nurses and graduate nurse staff will be sent on request. Address: Miss Alice L. Price, Hill-Rom Co., Inc., Batesville, Indiana.

Postsurgery Care Discussed At Anesthesiology Meeting

"A postanesthetic observation room is essential for the proper care of the patient immediately following surgery," Dr. Scott M. Smith, of Salt Lake City, Utah, told the annual meeting of the American Society of Anesthesiologists, held in Los Angeles, Oct. 14-18.

"A special unit near the operating room in which the surgical patient may recover from the anesthetic and surgical procedure under the constant supervision of specially trained personnel and where essential equipment is centralized to take care of any postoperative emergency is one of the significant advances in medical progress," he said.

Dr. Smith pointed out that regular "recovery rooms," already standard in many hospitals, are rapidly being augmented by acute surgical wards and acute medical rooms to maintain the highest quality of care in the face of shortages in nursing personnel.

"A surgical recovery room is a unit where surgical patients are kept until the critical postoperative period is over. This time would vary from one hour to several days, depending on the type of surgery done and the condition of the patient," Dr. Smith said, pointing out that the acute surgical room is operated 24 hours a day, rather than on the 8 a.m. to 5 p.m. basis of most recovery rooms.

The acute medical room is operated on the same principle, to care for heart attack patients, accidents, and other special cases.

Dr. Paul Lorhan, University of Kansas anesthesiologist, emphasized the importance of allowing elderly or geriatric patients to follow the same routine in the hospital that they did at home, and said that aging patients at the University of Kansas Medical Center are allowed to chew tobacco or take a nip of wine or roam around at night if they desire.

Elderly patients deprived of the habits they have been developing for 50 or 60 years are apt to become discouraged, Dr. Lorhan said, in emphasizing the need to make older patients want to live, if they are to come through surgery successfully.

He explained that about 15 per cent of the surgical procedures for which anesthesia is used are now performed on patients of 65 or over.

A number of papers were presented on fluothane, a newer drug offering qualities valuable in reducing danger of fires and explosion in operating rooms.

"In recent years a particular need has become apparent for a nonflammable and nonexplosive drug which is potent, easily reversible and safe," said Dr. C. R. Stephen, professor of anesthesiology at Duke University.

"Numerous clinical reports within the past year have corroborated the anesthetic properties and nonflammability of this drug," he said.

Approximately 1200 physician anesthesiologists attended the annual meeting. Dr. Ralph S. Sap-

Work Continues on AHA Headquarters

CONSTRUCTION continues on the new American Hospital Association headquarters building.

Structural steel framework of the new American Hospital Association headquarters building in Chicago was erected to the seventh floor level, as of Nov. 1. Completion and occupancy of the 12-story building are scheduled for early 1959.

Basement and sub-basement parking facilities are approaching completion. AHA hopes to lease these facilities soon.

The new building will contain an extensive library and reading area on the first floor, several conference rooms and classrooms on the second floor, and space for kitchen and dining facilities on the third floor.

Transcribing, duplicating, and mailing activities will be centered on the fourth floor. Floors 5 through 12 will be devoted to office space for Association activities and allied organizations.

A $10,000 Assist from New York

PRESENTATION of a $10,000 check from the Hospital Association of New York State toward construction of AHA's headquarters building was made by Lawrence J. Bradley, HANYS president, to Tol Terrell, AHA president. The presentation was made Oct. 28 during American Hospital Association council meetings in Chicago. Present were (l to r): Charles M. Royle, HANYS executive director; Mr. Terrell; Mr. Bradley, and Dr. Edwin L. Crosby, AHA director.

penfield, Miami, Fla., took office as president for the coming year, and Dr. Daniel C. Moore, Seattle, Wash., was named president-elect.

Harlem Hospitals Surveyed By New York Hospital Group

Hospital needs in the Harlem area of New York City will be studied by the Hospital Council of Greater New York, the council recently announced.

DR. NICHOLSON

Among the problems to be covered by the study, which is to be completed next spring, will be the status of hospital staff appointments of Negro physicians in New York City and how to increase the acceptance of such practicing doctors on the medical staffs of hospitals.

Dr. Hayden C. Nicholson, executive director of the council, stated that the purpose of the study was "to learn how the people of Harlem use hospital care today and project their needs into the future; and to answer as concretely as possible certain questions regarding the future of Harlem, Sydenham, and Knickerbocker hospitals . . ."

An attempt will also be made to develop an estimate of the size of health insurance enrollment in Harlem. The council stated that a preliminary study shows that "the proportion of [Harlem] residents with health insurance is by no means insignificant."

Lower Summer Occupancy Reported in Philadelphia

Total occupancy rate for 52 Philadelphia area hospitals during the quarter ended Aug. 31 was 74.2 per cent—the lowest quarterly rate in 21 months.

All the institutions reporting are voluntary general hospitals belonging to the Hospital Council of Philadelphia.

Individual groups reported as follows, according to the council: 23 "small" hospitals—74.3 per cent; 23 "large" hospitals—74.3 per cent, and six medical school hospitals—73.7 per cent.

During the summer quarter of 1956, occupancy was 77.1 per cent of capacity for these hospitals, the council stated. The nine "large" hospitals outside Philadelphia had the highest reported occupancy rate for this summer—77.3 per cent of capacity.

A total of 99,490 persons were admitted to the 52 hospitals during the quarter ended Aug. 31; this is an increase of 150 patients over the corresponding 1956 period.

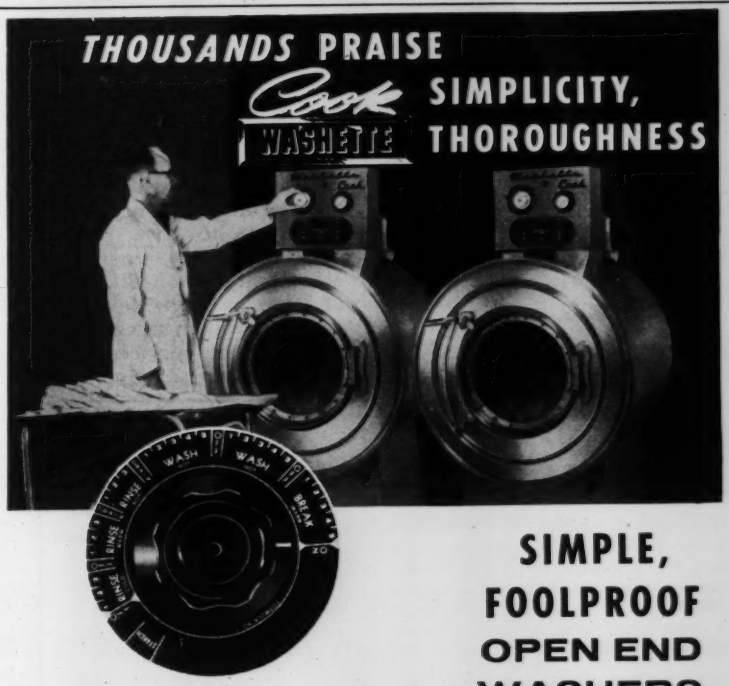
According to the council report, the Philadelphia area had a total bed complement of 13,113 beds during that quarter and an average of 9726 were occupied.

There was a slight increase in the birth rate this year, with a daily average of 214 reported births compared with 211 for the summer of 1956, the council reported. The hospitals reported a total of 621,031 outpatient visits during the quarter.

This past summer 8846 beds (67.5 per cent of the total complement) were classified as private and semiprivate, compared with 8461 beds (66.2 per cent of the total) last year.

The average length of stay for the period ended Aug. 31 was nine days, the council reported. There was a variation from 7.5 days in the "small" hospitals to 11.2 days in the medical school hospitals.

According to the council report



CHOICE OF 28 FORMULAE
•
COMPLETELY PLUMBED AND WIRED AT THE FACTORY
•
SINGLE POINT ADJUSTMENT

SIMPLE, FOOLPROOF OPEN END WASHERS

Cook WASHETTE

Today serving thousands of industries who do their own laundry; as well as commercial laundry and cleaning establishments. Offered in choice of 25, 50, 75, and 100 lb. capacities — cabinet or pedestal models. Full details without obligation.

Send for

FREE FOLDER

COOK MACHINERY CO., Inc., 4122-N Commerce St.
Dallas 26, Texas
Please send descriptive literature on COOK WASHETTES.
Name of Company_____
Signed_____ Title_____
Address_____
City and Zone_____ State_____
Type of Business_____

COOK MACHINERY CO., INC.
DALLAS, TEXAS
•
Phone TAylor 6-4158

USE

CABINET-SAN®

SPRAY DEODORANT

Economical, easy-to-use Cabinet-San removes stale smoke, perspiration, bathroom and sickroom (even ether, iodoform, and the odors connected with some disease cases) odors quickly, completely. Its deodorizing spray leaves a pleasant, lingering aroma.

Cabinet-San can be sprayed in inaccessible spots . . . deodorizes fabrics; will not stain or make them sticky.

Don't risk offending! Keep a can of Cabinet-San every place odors may occur. Now available in economical 16-ounce size cans. Also in refillable wick-type "continuous evaporating" or spray-type plastic bottles and in 1 gallon jugs.

Order Cabinet-San Today!

HUNTINGTON LABORATORIES
INCORPORATED
Huntington, Indiana
Philadelphia 35, Pa. • Toronto 2, Ontario

the "turn-over" rate declined slightly this year to 30.1 admissions per-bed per-year for the quarter ended Aug. 31, 1957, compared with 30.9 admissions per-bed per-year in 1956.

Washington State Services For Indigent Care Curtailed

Washington State's Department of Public Assistance is curtailing its indigent hospital care program because of budgetary considerations.

Dr. George A. Spendlove, head of the state's Division of Medical Care, said that expenditures in this category at the current rate would result in a $4.5 million deficit for the current biennium.

The new ruling, which was effective Oct. 1, is aimed at reducing the average hospital stay of welfare patients by one full day, stricter adherence to the policy of authorization of surgery, stricter adherence to care of "medical only" cases in emergency and acute conditions, reducing the cost of drugs by a new formulary, and curtailing other services.

Outpatient services are being cut drastically, Dr. Spendlove said.

Stuart Takes Executive Post With Blue Cross Association

James E. Stuart has been elected executive vice president of the Blue Cross Association, Dr. Basil C. MacLean, association president has announced.

MR. STUART

Since 1942 Mr. Stuart has served as executive vice president and director of the Hospital Care Corporation in Cincinnati, the Blue Cross Plan serving southwest Ohio. During part of that period he served as chairman of the Blue Cross Commission of the AHA and as a consultant to the Department of HEW.

Mississippi Council Formed

The Southwest Mississippi Hospital Council was recently formed, the Mississippi Hospital Association has announced. The council is the ninth autonomous area council affiliated with MHA.

CURRENT LISTINGS OF NEW ASSOCIATION MEMBERS

NEW INSTITUTIONAL MEMBERS

ARKANSAS

Benton—Saline Memorial Hospital.

FLORIDA

Miami—Miami Baptist Hospital.

ILLINOIS

Chicago—American City Bureau.
East St. Louis—Centreville Township Hospital.

INDIANA

Monticello—White County Memorial Hospital.

KENTUCKY

Frenchburg—Jane Cook Hospital.

LOUISIANA

New Iberia—Iberia General Hospital.

MARYLAND

Baltimore—Presbyterian Eye, Ear and Throat Hospital.
Reisterstown — Children's Rehabilitation Institute Inc. for Cerebral Palsy.

MINNESOTA

Ely—Ely-Bloomenson Community Hospital Corp.

NEW YORK

New York City—Division of Health and Hospitals, Catholic Charities of the Archdiocese of New York.

PENNSYLVANIA

Pittsburgh—Doctors' Hospital.

TENNESSEE

Memphis—City of Memphis Hospitals.

TEXAS

Fort Worth—Boulevard Hospital.

EL SALVADOR

San Salvador—Instituto Salvadoreno del Seguro Social.

NEW PERSONAL MEMBERS

Abels, Rose—pur. agent—Shadyside Hospital—Pittsburgh.
Anderson, George L.—bus. mgr.—Newington (Conn.) Home and Hospital for Crippled Children.
Antrim, Samuel E.—pur. agent—Wilmington (Del.) General Hospital.
Bennett, Edward D.—student hosp. adm.—Medical College of Virginia—Richmond.
Betts, Warren Romeo—student hosp. adm.—Medical College of Virginia—Richmond.
Blaszczyk, Edward S.—pur. agent—St. Francis Hospital—Evanston, Ill.
Bott, Thomas H.—adm. asst.—Hospital of University of Pennsylvania—Philadelphia.
Boyd, William Lester—student hosp. adm.—University of Chicago Clinics—Chicago.
Bozzo, Peter R.—pur. agent—Presbyterian Hospital in the City of New York—New York City.
Breuer, Bertram Leonard—student hosp. adm. — Northwestern University — Chicago.
Brouillette, Joseph H., Jr.—div. dir.—legal and security—Naval Hospital—Jacksonville, Fla.
Carter, Wade A.—pharm. and pur. agent—Gaston Memorial Hospital—Gastonia, N.C.
Chapman, Edward Daniel—supply off.—Naval Hospital—Jacksonville, Fla.
Clelland, R. A.—bus. mgr.—Arizona State Hospital—Phoenix.
Cole, Gerald B.—student hosp. adm.—University of Chicago—Chicago.
Coleman, William A.—asst. bus. mgr.—Southwest Florida Tuberculosis Hospital—Tampa.
Colon, Howard—student hosp. adm.—Medical College of Virginia—Richmond.
Comp, Estella Sharpley—asst. pur. agent—St. Mary's Hospital—Decatur, Ill.
Costello, Stanley J.—bus. rep. and dir. of pur.—St. Luke's Hospital—Aberdeen, S. Dak.
Coull, Thomas E.—student hosp. adm.—University of Chicago—Chicago.
Curtis, William H.—adm.—Parker Hill Medical Center—Boston.
Davis, Adison J.—pur. agent—Jameson Memorial Hospital—New Castle, Pa.
De Cesaris, Lt. C. A.—hosp. sup. off.—Naval Hospital—Philadelphia.
Dye, Paul W.—chief eng.—Boulder City (Nev.) Hospital.
Evers, Garlond E.—grad. student hosp. adm.—Medical College of Virginia—Richmond.
Gillman, James N., Jr.—pharm. and pur. agent—Graham Hospital Association and Training School for Nurses—Canton, Ill.
Goode, David Clyde—pur. agent—Irvington (N.J.) General Hospital.
Hartland, Edna E. — purveyor — Minneapolis (Minn.) General Hospital.
Hicks, Norma Ellen—asst. methods improvement off.—Army Hospital—Augusta, Ga.

YOURS IS NO TYPICAL CASE

There is no such thing as a typical hospital fund raising case so far as the John F. Rich Company is concerned. The needs and potentialities of each hospital constitute an entirely individual set of circumstances to be understandingly considered in planning and directing a fund campaign.

Experience in a wide variety of successful hospital campaigns has prepared our directors to handle your particular situation with skill and imagination. We invite you to discuss your fund-raising problems with us. No obligation of course.

The JOHN F. RICH COMPANY

3 Penn Center Plaza
Philadelphia 3, Pa.

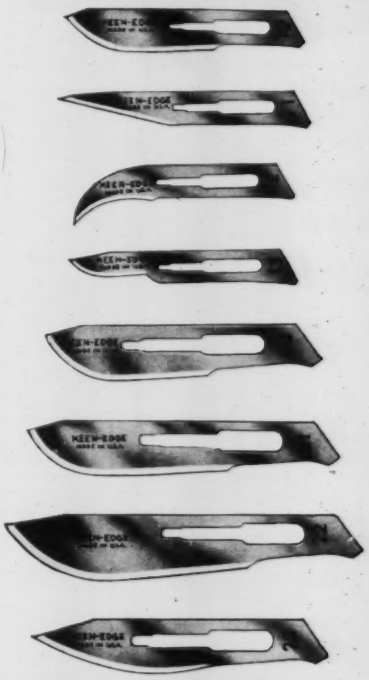
Member of the American Association of Fund-Raising Counsel

The P&S model M-8 is one of 27 stainless steel cabinets and tables in modern design. All drawers are equipped with ball bearing slides. Formica tops available in 8 colors. Electrical and air units in other models are suitable for both the EENT as well as the General Practitioner.

Write to

P&S MEDICAL EQUIPMENT
14525 Arminta Street
Van Nuys, California

WOULD YOU TRY KEEN-EDGE® SURGICAL BLADES AT OUR RISK?



A TOP QUALITY BLADE AT A MONEY-SAVING PRICE

We guarantee "Keen-Edge" Blades to be as sharp as any you have ever used or it's "no sale". "Keen-Edge" Blades are made for us exclusively by one of the largest manufacturers and, except for the name, are identical to his nationally advertised and higher priced product.

You pay as little as $9.25 per gross in quantity for "Keen-Edge". Single gross price only $12.00. Send a trial order today. Use 2 dozen in your surgery. If not completely satisfied return the rest for full refund. The trial costs you nothing. Specify individual wrap or rack package.

"GREEN CROSS"
RUBBERLESS ELASTIC BANDAGES ARE ALSO BUDGET SAVERS.

PRICES UPON REQUEST.

Wocher's

YOUR COMPLETE HOSPITAL SUPPLY HOUSE
609 COLLEGE STREET CINCINNATI 2, OHIO

America's most popular nurser

Cut bottle preparation time 20% with **evenflo** nursers

A time-study check at a leading metropolitan hospital* proves that use of Evenflo Nursing Units cuts over 65 minutes from the average time required to prepare 100 bottles for feeding — a saving of 20%!

The study compared use of 1,000 Evenflo Units with that of an equal number of narrow neck bottles and nipples. Evenflo Nursers cut 10 hours, 55 minutes, from the daily workload, released needed personnel for other duties. The hospital report stated that Evenflo's widemouth bottles saved time during cleaning and pouring, and that sterile nipples were positioned for feeding faster, more easily and without being touched.

Evenflo Units continue paying for themselves. Their easy-to-use caps and discs prevent contamination and waste of formula, while their higher thermal shock range reduces breakage and replacement.

See how Evenflo Nursers can reduce your hospital's workload, save time and money. Call your local Evenflo dealer, or write direct to Evenflo, Ravenna, Ohio.

*Copies of the Report of Infant Feeding Process available on request.

Used by more mothers than all other nursers combined.

NEW **evenflo** SILICONE NIPPLE CUTS REPLACEMENT COSTS

- *Lasts 8 to 10 times longer*
- *Saves time — easier to clean*
- *Inert material resists clogging*
- *Will not change shape*

evenflo®

EVENFLO, Ravenna, Ohio

Hiers, Terry, Jr.—adm.—Americus (Ga.) and Sumter County Hospital.
Ingbritsen, Keith Eugene—student hosp. adm.—University of Minnesota—Minneapolis.
Jackson, George W.—student hosp. adm.—Northwestern University—Chicago.
Joyce, William D.—pur. agent—Jackson Memorial Hospital—Kendall, Fla.
Kanagy, Gene Forrest—student hosp. adm. —Northwestern University—Chicago.
Kerwin, Philomena Frances—national dir. —National Catholic Community Service —Washington, D.C.
Kirkpatrick, Col. Charles L.—comm. off.—DeWitt Army Hospital—Fort Belvoir, Va.
Lauth, Glen H.—adm. res.—Silver Cross Hospital—Joliet, Ill.
Leiser, Dean E.—student hosp. adm.—University of Chicago—Chicago.
Limi, Fosca—pur. agent—Mercy Hospital —Bakersfield, Calif.
MacRae, Frederick J.—dir. of serv.—Mid Island Hospital—Bethpage, N.Y.
Maxwell, John H.—pur. agent—Waterbury (Conn.) Hospital.
McAllister, R. Kirk—pur. agent—Hinsdale (Ill.) Sanitarium and Hospital.
Morris, Henry Joseph—adm. res.—Grace Hospital—Detroit.
Patterson, Thelma I.—pur. agent—McLaren General Hospital—Flint, Mich.
Pelton, Raymond L.—student hosp. adm.—Northwestern University—Chicago.
Price, Lionel Gene—adm. res.—Methodist Hospital—Indianapolis.
Pridgen, Lee—student hosp. adm.—University of Chicago—Chicago.
Reeves, Robert B. — supt. — Nightingale Hospital—El Campo, Tex.
Rentschler, Walter R.—student hosp. adm. —Columbia University—New York City.
Brother Jeroma Revak—maint. engr.—Alexian Brothers Hospital—Chicago.
Robinette, Jack C.—grad. student hosp. adm.—University of Chicago—Chicago.
Rubino, Frank E.—pur. agent—Lower Bucks County Hospital—Bristol, Pa.
Rud, Clarence D.—chief engr.—St. Joseph-Lloyd Hospital—Menominee, Mich.
Ryan, Daniel P.—bus. mgr.—Mercy Hospital—Denver.
Shawver, James Russell—student. hosp. adm.—University of Chicago—Chicago.
Sister Mary Alexis—pur. agent—Misericordia Hospital—Philadelphia.
Sister Mary Anthony—pur. agent—St. Michael's Hospital—Toronto, Ontario, Canada.
Sister Mary Assumpta—adm.—St. Joseph Mercy Hospital, Aurora, Ill.
Sister M. Theresa—adm.—St. Joseph Hospital—Joliet, Ill.
Starkweather, David B.—student hosp. adm.—Columbia University—New York City.
Straw, Harry E.—chief engr.—Glens Falls (N.Y.) Hospital.
Tobin, John Henry, Jr.—student. hosp. adm.—Medical College of Virginia—Richmond.
Wing, Donald Ray—dir. of pur.—Montreal (Quebec) Children's Hospital.
Winters, Kenneth L.—hosp. adm. consultant—United States Overseas Mission to Brazil—Rio de Janeiro.

HOSPITAL AUXILIARIES

Mercy Hospital Auxiliary—Brinkley, Ark.
Women's Auxiliary of the Greater Bakersfield (Calif.) Memorial Hospital.
Friends of Ingleside Lodge—South San Gabriel, Calif.
St. Joseph's Hospital Auxiliary—Stockton, Calif.
Naples (Fla.) Community Hospital Auxiliary.
Women's Auxiliary of the Franklin Boulevard Community Hospital—Chicago.
Holy Cross Hospital Women's Auxiliary—Chicago.
Woman's Board-Mercy Hospital—Chicago.
Mercy Hospital Women's Auxiliary—Urbana, Ill.
Woman's Board of John Graves Ford Memorial Hospital—Georgetown, Ky.
Brunswick (Maine) Community Hospital Auxiliary.
Auxiliary of Fairlawn Hospital—Worcester, Mass.
Mercy Hospital Women's Auxiliary—Benton Harbor, Mich.
Highland Hospital Auxiliary—Beacon, N.Y.
Women's Auxiliary of the Salvation Army-Booth Memorial Hospital—Flushing, N.Y.
Strong Memorial Hospital Aide Service—Rochester, N.Y.
Council of Auxiliaries to the Centre County Hospital—Bellefonte, Pa.
Woman's Auxiliary of Medical Center Hospital—Tyler, Tex.

A 10-year look at uniform cost accounting

(Continued from page 55)

slower, but much more moderate. The time lag between when costs are determined and when they are paid under the state and county reimbursement arrangements accounts for a major portion of the difference between the actual cost of service when rendered and the amount now being paid by the state and county as shown in Table 2.

PUBLIC RELATIONS ASPECT

Because the rise in hospital costs over the last 10 years has been at a somewhat higher rate than the over-all cost of living increase, hospitals have been singled out for a great deal of criticism. Hospitals and Blue Cross in western New York have been able to explain this rise in costs on a local, scientific basis provided by the uniform cost findings. Hospitals should not need to make apologies for the cost aspects of their operation but an explanation of cost has public relations value.

With industry being called upon more and more to make very substantial contributions either for capital expenditures or to offset operating deficits, industrial management tends to look with a jaundiced eye upon wide and unexplained variations in the costs between relatively comparable institutions in the same community. They welcome the availability of uniformly comparable cost figures. There have been, in fact, a number of instances where the amount of recent contributions made to institutions in the area has been markedly greater by a particular company. Statements have been made that these larger donations were made because the donors had reason to believe their money was being efficiently used.

Both the Western New York Hospital Council as an official body and 32 out of the 34 member hospitals of the plan have repeatedly voiced approval of and enthusiasm for the program during the last three years. Administrators and trustees subscribe to the advantages listed in this article. It has been suggested that we now consider expanding this plan and similar cooperative endeavors. ■

prn

PRO RE NATA

JOHN H. HAYES

Most people do not like to take orders from others. That's why nurses marry doctors and secretaries marry their bosses.

★ ★ ★

Inflation, apparently, is due to the desires of humans to get more and more for their efforts or products.

★ ★ ★

HOSPITAL LIMERICKS

An obstetrician in Troy,
When asked to predict girl or boy,
Would tell each new mother,
"Twill be one or the other,
But either will bring you great joy."

A resident doctor named Dove
Is married and deeply in love.
When patients need care
He so rarely is there,
They ask, "What's he resident of?"

A psychiatrist told him he will
Need shock treatment, for he was ill.
The patient then sighed,
Thought a while and replied,
"O.K. Doc. Just send me your bill."

★ ★ ★

Things I always wanted to do:

1: Write a book for boys, about a lad named Philip Grimm; and entitle it "Phil Grimm's Progress".

2: Build a home to live in on my retirement from hospital work, and name it "DUNFRETTIN".

★ ★ ★

I sometimes think that the growth in the number of psychiatrists parallelled the drop in the number of what we called family doctors.

'spossible.

★ ★ ★

Now again, all the students are back in school and college classrooms, learning, so as to be able to earn more and thus be able to pay more to others who, having learned more, will want to earn more.

★ ★ ★

The trouble with a long vacation is that it always leaves you so fully rested that you don't want to go back to work.

★ ★ ★

HOSPITAL PHONE-ETICS:

"Hello. What are the hospital visiting hours?"

"Is the patient in Private, Semi-private or Ward?"

"What difference does it make?"

"They have different visiting hours."

"I don't know where the patient is."

"What is the patient's name?"

"Sam . . . I forget his last name."

"We have lots of patients named Sam."

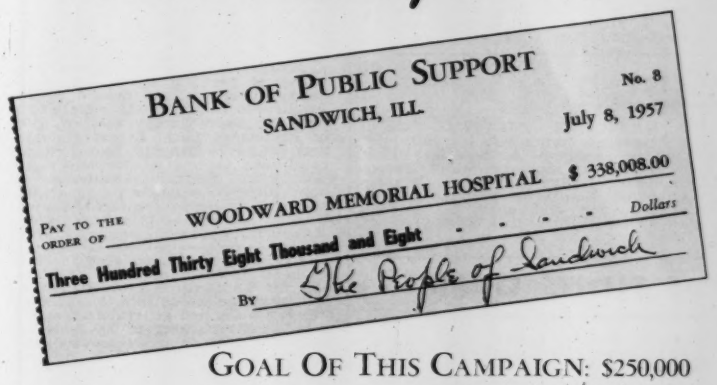
"What hospital is this?"

"Samaritan."

"That's it! Arritan. Sam Arritan."

"I'm sorry. Mr. Arritan was discharged this morning."

ANOTHER *Haney* VICTORY!



GOAL OF THIS CAMPAIGN: $250,000

RAISED $338,008

HANEY campaigns are conducted to encourage the participation of the greatest number of people. From more than a third of a century's experience with hospital campaigns we know that over-subscriptions and better public relations result from careful "depth" campaigning.

Here is an actual breakdown of fund-giving at Sandwich, Illinois:

* 2 -	gifts of $ 10,000 or more	$ 25,000.00
* 51 -	gifts of $ 1,000 to $ 9,999	109,150.00
* 48 -	gifts of $ 500 to $ 999	43,105.00
* 635 -	gifts of $ 100 to $ 499	102,600.00
*2469 -	gifts of less than $ 100 each	58,153.00
		$ 338,008.00

** - Since the formal conclusion of the campaign, additional gifts have substantially raised the above totals.

MORE THAN A THIRD OF A CENTURY OF SUCCESSFUL SPECIALIZATION

HANEY ASSOCIATES INC.

797 WASHINGTON ST. DECATUR 2-6020
NEWTONVILLE 60, MASSACHUSETTS

Specialists in Successful Hospital Campaigns for over 30 years

CONSULTATION ON YOUR FUND-RAISING PROBLEM
WITHOUT OBLIGATION OR EXPENSE

CLASSIFIED ADVERTISING

Classifications: Classified advertising accepted to run under the following headings: 1—Services; 2—Instruction; 3—Wanted; 4—For Sale; 5—Positions Wanted; 6—Positions Open; 7 Miscellaneous.

Transient Rate: Thirty cents a word; minimum charge $4.50 per insertion.

Contract Rate: Six-point body lines, 13 pica columns, $1.40 per line; eight-point display lines $1.70 per line. Five per cent discount for twelve-insertion contracts with no change of copy.

SERVICES

DISASTER PLANNING consulting service to aid your industry or institution to prepare plans of action in case of fire, flood, natural disaster or civil defense situations. Timothy G. Stillman, P.O. Box 54B, Cornwall-on-Hudson, New York.

WANTED

NEED NATIONAL DISTRIBUTION? Highly respected, nationwide supplier to the medical, surgical & hospital field wishes to take on non-competing items which can meet rigid requirements. If you have developed a superior product enjoying local success and want to sell it throughout the U.S. Write HOSPITALS, Box H-96.

POSITIONS OPEN

DIRECTOR—NURSING SERVICE: 60 bed general hospital, fully accredited, expansion program, liberal salary range and employee benefits. Midwest, population 10,000. Rail and bus connections excellent to larger cities. Contact HOSPITALS, Box H-97.

CHIEF DIETITIAN: Modern teaching hospital in Boston area has opening on February 1st, or sooner, for Chief Dietitian. Applicant must have administrative experience at least at assistant chief level. Must supervise large department including teaching and therapeutic dietitians and food service supervisors. Excellent opportunity. Salary open. Write giving details to HOSPITALS, Box H-98.

BUSINESS MANAGER—male—for 65-bed hospital in process of expanding to 105 beds. Must be experienced in fund accounting and able to assume responsibility. Excellent working conditions, 40-hour week. Salary open. Lake Forest Hospital, Lake Forest, Illinois.

REGISTERED NURSE ANESTHETIST: 34 bed hospital, Montana. 5 doctors, one board surgeon. $525.00 per month. No nursing duties. Vacation and sick leave benefits. Relief anesthetist available. For further information contact, H. A. Kallio, Administrator, St. John's Lutheran Hospital, Libby, Montana.

ANESTHETIST-NURSE. For 250 bed general hospital. Excellent working conditions and personnel policies. Good starting salary. Write: Mr. Bert Stajich, Assistant Administrator, Columbia Hospital, 3321 N. Maryland Avenue, Milwaukee 11, Wisconsin.

NURSE ANESTHETIST: full time or relief, for 50 bed hospital in lively resort area. Excellent working conditions and reasonable salary. Apply Administrator, Memorial Hospital, North Conway, New Hampshire.

DIETITIAN: Assistant. 150 bed modern general hospital. Ideal climate, excellent opportunity, starting salary $4200. Apply Administrator, Yakima Valley Memorial Hospital, Yakima, Wash.

CONTROLLER: Madison General Hospital a 360 bed, non-profit, non-governmental general hospital needs a budget and fiscal officer to establish and administer operating cash and capital budgets. Individual should have a B.A. degree in accounting or a B.B.A. degree with a major in accounting and experience in a responsible fiscal position. Applicant must have a demonstrated ability to handle finances and direct the accounting, credit and collection activities, business office and admitting activities of a general hospital. Write, giving resume of background to D. C. Reynolds, Administrator, 925 Mound Street, Madison 5, Wisconsin.

CLINICAL INSTRUCTORS needed in the following areas: (1) operating room technique (2) medical and surgical nursing (3) pediatric nursing. Day, evening and night shifts. Integrated program; affiliated with Drake University; 200 students in school; 400 bed, fully approved, non-profit hospital. Minimum qualifications: B.S. degree, preferable in nursing education. Salary open. 40-hour work week; 20 working days vacation; sick benefits. Position open immediately. Apply Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

DIRECTOR—NURSING SERVICE AND EDUCATION: 300 bed general hospital, with 150-student school of nursing, and expansion program in progress, needs Director of Nursing to be responsible for Nursing Service and School of Nursing. Applicants should be in excellent health, between approximate ages of 35-45 and of Protestant faith. Liberal salary range and employee benefits. Excellent working conditions in one of Midwest's foremost institutions, centrally located in city and convenient to outstanding residential and shopping facilities. Contact, Personnel Director, Milwaukee Hospital, 2200 West Kilbourn Avenue, Milwaukee 3, Wisconsin.

DIETITIAN: If you are ready to take over as head of the department and are looking for an unusual and challenging opportunity we would like to hear from you. We are a 250 bed general community hospital soon enlarging to 500 beds. Starting salary is $6,000. Four weeks vacation. Write or phone collect to Mr. E. C. Pohlman, Administrator, Grant Hospital, Columbia 15, Ohio.

EXECUTIVE HOUSEKEEPER—350 bed hospital located in desirable eastern resort area has an immediate opening. Person we are seeking must have knowledge of work simplification, housekeeping standards and employee training. 55 in Department. Excellent opportunity for Executive Housekeeper in smaller hospital seeking advancement. Address HOSPITALS, BOX H-94.

ASSISTANT REGISTERED MEDICAL RECORD LIBRARIAN: Standard nomenclature. 353-bed general hospital. Excellent working conditions and employee benefits. 40-hour week. Salary commensurate with experience and ability. Job description furnished on request. Apply Personnel Office, California Hospital, 1414 South Hope Street, Los Angeles 15, California.

NURSE ANESTHETIST—2. 110 bed J.C.A.H. fully approved Hospital. 1 immediate vacancy, 1 vacancy Feb. 1st. Anesthesiologist in charge of department. Good personnel policies and salaries. Apply: Dr. William Colantoni, M.D., Anesthesiologist, Brownsville General Hospital, Brownsville, Pa.

ANESTHETIST wanted by fully accreditated rural hospital: Southwest: F.A.C.S. surgeon; ideal location for nurse who likes small towns. General surgery, and OB, rare emergency calls: Salary open: write or wire Box H-93, HOSPITALS.

HOSPITAL PERSONNEL BUREAU

220 E. Lexington St. Baltimore 2, Md.
No registration fee. LExington 9-5029
C. J. Cotter Associates R. J. E. Guild

NATION-WIDE PLACEMENT SERVICE

Openings for Physicians, Administrators, Anesthetists, Dietitians, Director of Nursing, Instructors and all RN Categories; Lab. and X-ray Technicians, Phys. Therapists, Social Workers, Pharmacists. Exect. Housekeepers, Comptrollers and all hospital categories.

Licensed Employment Agent

LIBRARIAN, MEDICAL RECORD—Registered. To assume charge of record room. 135 bed general hospital, 40 hours—salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland, Ohio.

PURCHASING AGENT: Top level executive position. Director of department handling several million dollars worth of purchases a year in one of the largest medical centers in the country. Salary open for well qualified man with suitable experience in hospital purchasing. Send full particulars with photograph to the executive director, Michael Reese Hospital, 29th Street and Ellis Avenue, Chicago 16, Illinois.

POSITIONS WANTED

ANESTHETIST: 16 years experience. Western Reserve graduate. All types anesthetics. Address HOSPITALS, Box H-92.

Telephone RAndolph 6-5682

When progress in your field of medicine, hospital administration, nursing or laboratory work dictates a change of location, only the most advantageous opening deserves your interest. Likewise, when your hospital or clinic requires well qualified personnel on the administrative level, diplomates to head departments or ancillary personnel, only the best available candidate is acceptable. At this juncture, you can gain time and efficiency by delegating the details of your search to the Woodward Medical Personnel Bureau. Our service is strictly confidential. *We invite your inquiries—and your attention to our excellent listings in the forthcoming first-of-the-month issue.*

THE MEDICAL BUREAU

M. Burneice Larson—Director

900 North Michigan Ave.

Chicago 11, Illinois

To physicians, hospital administrators, nursing executives and others in the hospital and medical fields confronted with the delicate but important problem of relocating, the physician in need of an associate, or the institution reorganizing or augmenting its staff, Burneice Larson offers the services of The Medical Bureau. All negotiations strictly confidential. Opportunities in all parts of America, including countries outside continental United States. Please note our descriptions of opportunities in the first issue of each month of Hospitals. Write us please for further details.

MARY A. JOHNSON ASSOCIATES

AGENCY

11 West 42 Street New York 36, N.Y.

Mary A. Johnson, Ph.D., Director

FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidates, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists and other supervisory personnel.

No registration fee

THESE AMERICANS AND 800,000 OTHERS ARE

CURED OF CANCER

Alive today . . . because they went to their doctors *in time!*

Every year more and more Americans are being cured of cancer. But the tragic fact, our doctors tell us, is that every sixth cancer death is a *needless* death. So many people just don't consult their doctors when the disease is in its early . . . and therefore more curable . . . stage.

Let's give our doctors a chance to head off cancer in time! Form the life-saving habit of a head-to-toe health checkup once a year. For men, this should include a chest x-ray; for women, a pelvic examination.

Make it a habit . . . for *life*.

AMERICAN CANCER SOCIETY

ADVERTISER'S INDEX - - - - - November 16, 1957

Abbott Laboratories ..... Facing Page 76
Air-Shields, Inc. 4
Allis-Chalmers Manufacturing Co.
Buda Division 6
American Cyanamid Company
Surgical Products Division 1
American Home Foods, Inc. 107
American Laundry Machinery Company . . Facing Page 92
A. S. R Hospital Division 91
American Sterilizer Company 15
Armour Laboratories 13
Ayerst Laboratories 8

Bauer & Black
Division of The Kendall Company 73
Baxter Laboratories
110, 111, Facing Page 20, Third Cover
Becton, Dickinson & Company 33
Blickman, Inc., S. 7
Brewer Company, E. F. 12
Bristol-Myers Company 67

Chef Boy-Ar-Dee 107
Chesebrough-Pond's, Inc. 94
Cancer Advertisement 123
Classified Advertising 122
Cook Machinery Co., Inc. 117
Crane Company 42, 43
Crimsco, Inc. 87
Cutter Laboratories 63

Davis & Geck 1
Deknatel & Son Inc., J. A. 41
Don & Company, Edward 96

Eastman Kodak Company 65
Eichenlaubs 96

Fisher Scientific Company 40
Flex-Straw Company 99

General Electric Company, X-Ray Dept. 29

Haney Associates Inc. 121
Hausted Manufacturing Company ..... Second Cover
Hill-Rom Company 115
Hobart Manufacturing Company 16
Hoffmann-LaRoche, Inc. 44

Hollister & Company, Franklin C. .... Facing Page 108
Huntington Laboratories 118

International Business Machines Corp. 85
International Nickel Company, Inc., The 112

Ketchum, Inc. 97

Lilly & Company, Eli 2

McKesson & Robbins, Inc. 31
Meals-On-Wheels 87
Minneapolis-Honeywell Regulator Company 36, 37
Minnesota Mining & Manufacturing Co. 71

National Cylinder Gas Company ..... Facing Page 28

Onan & Sons, D. W. 34
Otis Elevator Company 10, 11

P & S Medical Equipment 119
Parke, Davis & Company ..... Fourth Cover
Physicians' Record Company 95
Pioneer Rubber Company 79
Plextone Corporation of America 35
Polar Ware Company 89
Porto-Lift Manufacturing Co. 38
Puritan Compressed Gas Corp. 81
Pyramid Rubber Company 120

Rich Company, John F., The 119
Roche Laboratories
Division of Hoffmann-LaRoche Inc. 44

Sexton & Company, John 103
Simmons Company 14

Torrington Company 32
Travenol Laboratories, Inc.
Division of Baxter Laboratories, Inc. .... Third Cover

Vestal, Inc. 82, 83
Vinyl Plastics Inc. 9

Wallace Laboratories 5
Weck & Company, Edward 75
West Disinfecting Company 39
Wocher & Son, Max 119
Wyeth Laboratories 69

PICTURE CREDITS

p. 30 The Zito Studios
p. 48 (BOTTOM) Hopital Americain Service Photographique
(OTHERS) Russell Melcher—Pix Incorporated
p. 49 Russell Melcher—Pix Incorporated
p. 50 (UPPER TWO AND CENTER LEFT) American Hospital of Paris
(OTHERS) Russell Melcher—Pix Incorporated
p. 51 Russell Melcher—Pix Incorporated
p. 52 (BOTTOM RIGHT) Hopital Americain Service Photographique
(OTHERS) Russell Melcher—Pix Incorporated
pp. 56, 57 Ted Bruehl
p. 66 Photographic Department, University of Minnesota
p. 80 Institutional Feeding and Housing
p. 90 Photographic Department, Rhode Island Hospital
pp. 101, 102 Photographic Department, University of Oregon Medical School
p. 116 (TOP) Stephen Lewellyn
(BOTTOM) Staff photo—Fritz

INCERT®

new... unique one-step additive vial saves time, labor and money in your hospital

NO AMPULES... NO NEEDLES ...NO SYRINGES

Simply remove tamperproof cover of INCERT and push sterile plug-in through large hole in stopper of solution bottle. It's that easy... and a completely closed, sterile system.

EXCLUSIVE HOSPITAL-USE FEATURES

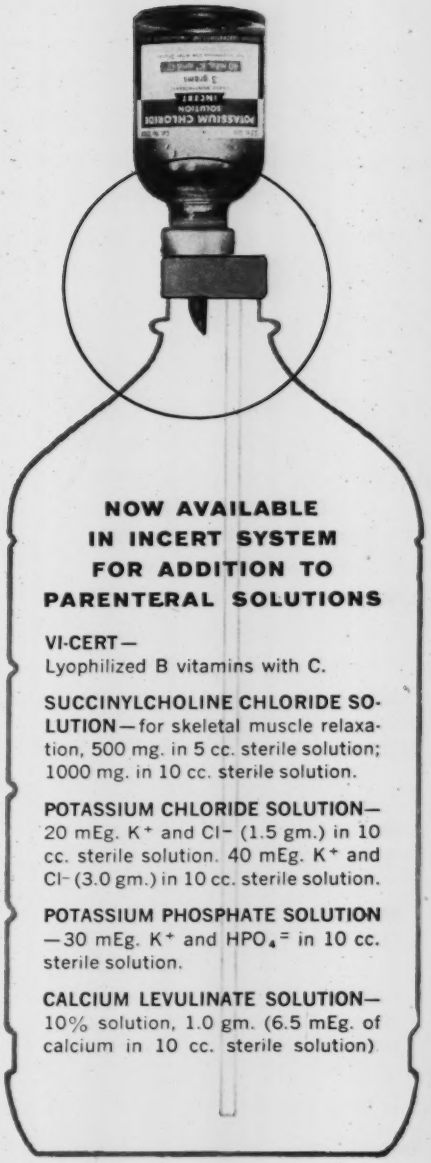
CONSERVES TIME — Instantaneous automatic supplementation of bulk parenteral solutions.

COMPLETELY STERILE—Closed system, from preparation to administration.

ECONOMICAL—Cuts labor and expense by eliminating ampules, needles and syringes.

SIMPLE TO USE—A foolproof system that eases the hospital care load.

***INCERT SYSTEM** is an original development of Travenol Laboratories, Inc. Complete literature and samples on request.*



NOW AVAILABLE IN INCERT SYSTEM FOR ADDITION TO PARENTERAL SOLUTIONS

VI-CERT—
Lyophilized B vitamins with C.

SUCCINYLCHOLINE CHLORIDE SOLUTION—for skeletal muscle relaxation, 500 mg. in 5 cc. sterile solution; 1000 mg. in 10 cc. sterile solution.

POTASSIUM CHLORIDE SOLUTION—20 mEg. K^+ and Cl^- (1.5 gm.) in 10 cc. sterile solution. 40 mEg. K^+ and Cl^- (3.0 gm.) in 10 cc. sterile solution.

POTASSIUM PHOSPHATE SOLUTION—30 mEg. K^+ and $HPO_4^=$ in 10 cc. sterile solution.

CALCIUM LEVULINATE SOLUTION—10% solution, 1.0 gm. (6.5 mEg. of calcium in 10 cc. sterile solution)

TRAVENOL LABORATORIES, INC. MORTON GROVE, ILLINOIS

Pharmaceutical Products Division of **BAXTER LABORATORIES, INC.**

IN

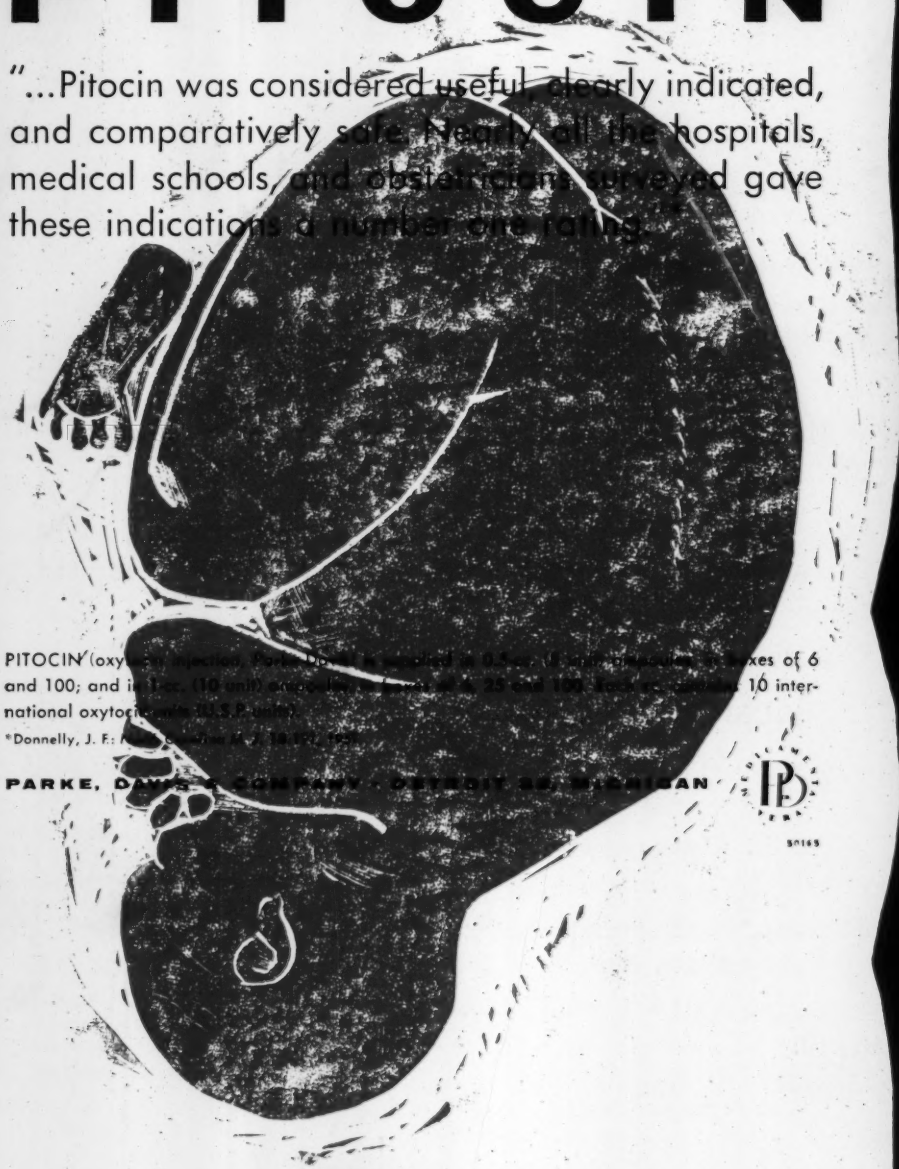
—uterine inertia—primary and secondary

—third stage of labor

—postpartum hemorrhage due to uterine atony

PITOCIN®

"...Pitocin was considered useful, clearly indicated, and comparatively safe. Nearly all the hospitals, medical schools, and obstetricians surveyed gave these indications a number one rating."*



PITOCIN (oxyt[illegible] injection, Parke-Davis) is supplied in 0.5-cc. (5 units) ampules, in boxes of 6 and 100; and in 1-cc. (10 unit) ampules, in boxes of 6, 25 and 100. Each cc. contains 10 international oxytocic units (U.S.P. units).

*Donnelly, J. F.: [illegible] Am. J. Ob. & Gyn., 1950.

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN

5M155

University Microfilms
313 North First Street
Ann Arbor, Mich.